PROGRAM DESCRIPTION

NGO NETWORKS

I. INTRODUCTION

USAID Guatemala/Central American Programs (G-CAP) seeks a qualified organization to develop and strengthen non-governmental organization (NGO) networks working in the health sector in Guatemala. These networks will expand coverage of basic reproductive and child health (RCH) services in seven priority departments in the Central and Western *Altiplano* region of Guatemala. These are the departments of San Marcos, Totonicapán, Sololá, Quetzaltenango, Chimaltenango, Quiché and Huehuetenango. The purpose of this program is to increase the use of RCH services by improving their quality, accessibility and management. USAID plans to award a Cooperative Agreement for a period of three years, beginning by October 2001 and continuing through September 2004 when the Mission's current health strategy concludes. Subject to the availability of funds, USAID/G-CAP plans to make $6.0 million available for this Cooperative Agreement over the three-year life of the activity.

II. BACKGROUND

A. Description of the Strategic Objective

USAID/G-CAP supports five sustainable development strategic objectives (SOs) in Guatemala in the areas of, democracy, income generation, health, education and environment. The Mission also supports two special objectives to support the implementation of the 1996 Peace Accords and for reconstruction of damage caused by Hurricane Mitch. The goal of the health SO, *Better Health for Women and Children*, is to improve the health status of women and children throughout the country and, by focusing efforts on selected departments of the *Altiplano* region, to bridge the enormous gap between rural, Mayan populations and the rest of the country. The essence of the USAID/G-CAP approach is to turn the traditional top down development approach around to involve directly the beneficiaries of public health programs in project design, implementation, monitoring and evaluation. The ultimate customers should help to define the kind of services desired and actively participate in determining how those services will be provided.

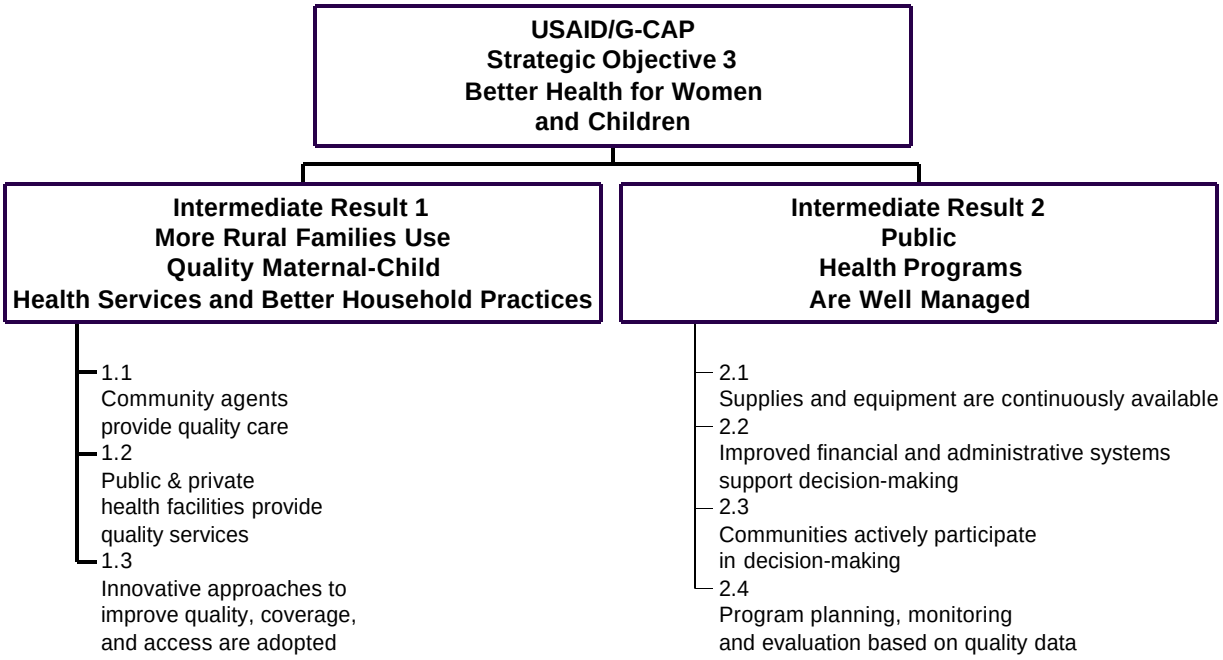
The history of neglect and ill treatment by the health sector has made the Mayan population in particular distrustful and suspicious of health services and health care providers. Strong traditional beliefs about elements of reproduction, women's health and children's health are often in conflict with the health sector's emphasis on modern recommendations or procedures, including family planning methods and drug therapies. Poor service quality from clinics and community health workers - untrained in necessary information, interpersonal communication and referral skills - has given family

planning a bad "word of mouth" reputation which has been taken advantage of by certain groups to instill fear and misinformation regarding contraception. Women suffer from, but are unaware of treatment or prevention possibilities for reproductive tract infections, cervical cancer, and sexually transmitted diseases. For child health, commercial pressures and non-optimal breast feeding practices shorten the interval for birth spacing and increase the likelihood of infection, giving early initiation to the cycle of malnutrition and infectious disease in children. Health workers' inadequate interpersonal communication and counseling skills are associated with poor drug compliance and/or delayed use of medical care, leading to elevated child mortality from pneumonia and acute diarrhea diseases.

1. Strategic Objective 3: Better Health for Women and Children

USAID has adopted a Results Framework to guide partners in implementing activities in support of the SO, *Better Health for Women and Children*. The proposed project focuses on two of the three Intermediate Results (IR), as shown in Figure 1. The Lower-level Results (LLR) are also shown for each Intermediate Result.

Figure 1: Results Framework for the NGO Network Program



2. National health indicators

USAID/Guatemala has selected two indicators to evaluate the combined performance of all partners in achieving the strategic objective. Table 1 shows the 1998-9 values for these indicators as well as the targets for 2002.

Table 1: National Health Indicators

Indicators	1998-9	2002
Infant mortality rate	45/1,000 live births	41/1,000 live births
Total fertility rate	5.0	4.8

3. Current NGO activities supported by USAID

USAID has been supporting the delivery of RCH services through several mechanisms, including Cooperative Agreements with APROFAM, IPROFASA, the Population Council, Project Concern International and a Strategic Objective Grant Agreement with the Government of Guatemala to support the Ministry of Health (MOH) and the Guatemalan Social Security Institute (IGSS). In order to broaden coverage beyond the reach of the public sector and APROFAM, local NGOs were identified as key to improving access to RCH services, particularly in rural areas and the Western *Altiplano* region, which are priorities under the Strategic Objective. In addition to support to APROFAM, USAID is supporting local NGOs in three initiatives. The new project is expected to build on the experience and accomplishments of these initiatives.

The Population Council. In 1996 the Cooperative Agreement with the Population Council was modified to add a second element to assist local NGOs in implementing new strategies for service provision that were developed under the Council's Operations Research (OR) element. The Council agreed to provide technical assistance, training, financial support and (since 1999) contraceptives donated by USAID, to help NGOs introduce or expand Reproductive Health (RH) and child health services through the introduction of the Integrated Management of Childhood Illnesses (IMCI) approach.

The Council has been working with nine NGOs, three of which have their own networks of other interested NGOs, for a total of 23. An additional 65 NGOs that are part of the three networks have benefited from replication of training and the provision of IEC materials and contraceptives.

With the exception of an NGO located in Jalapa, and another in Retalhuleu, these NGOs work with rural, Mayan populations located in the Central and Western *Altiplano* region. They offer both clinical and community-based RCH services. The total population covered by these 21 NGOs is approximately 300,000. See Annex B for a descriptive listing of these NGOs.

The Cooperative Agreement with the Council ends December 31, 2001 and the sub-agreements with the NGOs end October 30, 2001.

Population Concern International. USAID also has a Cooperative Agreement with Project Concern International (PCI) that began in September 1997 and will continue through Sept. 2001. PCI is currently working with nine NGOs that cover a population of about 250,000. It also provides training,

technical assistance, contraceptives and financial support.

Sistema Integral de Atención en Salud (SIAS), Programa de Extensión de Cobertura (PEC). This is an MOH program that began in 1997, largely with funding from the InterAmerican Development Bank. The purpose of this program is to extend basic health services to high-risk, impoverished rural and indigenous populations through capitation agreements with NGOs. NGOs that apply and are certified agree to provide a set package of 24 basic clinical and community-based services for a set per-capita payment. The package includes most of the basic RCH services, environmental health interventions and services related to malaria, dengue, rabies and tuberculosis. An effective management information system known as "SAS" has been developed by the University Research Corporation (URC) and its subcontractor Forja for use by the SIAS NGOs. Promoting use of this MIS system to both SIAS and non-SIAS NGOs should be considered by the Applicant and applied where appropriate. Approximately 36 NGOs have agreements with SIAS to provide RCH services to rural Mayan communities.[1] See Annex D for an overview of SIAS/PEC.

SIAS is a significant part of USAID support to the MOH. In addition, URC has been contracted by the Mission to provide technical assistance, training and financial support to the MOH and IGSS to strengthen public sector programs, including SIAS and its NGO partners. Subcontractors to URC are the Population Council, EngenderHealth (formerly AVSC), JHPIEGO and the John Hopkins Center for Communication Programs. This task order, which was signed in December 1999, is known locally as "*Calidad en Salud*." It will continue through September 2003.

4. Design elements

To be successful, this new NGO project must be sensitive to, and address, a number local concerns. Among these are four that are especially significant:

Client/Mayan focus: Despite best intentions and competent service provision, no program of health and family planning services can succeed without knowledge of and sensitivity to cultural factors. A client focus implies a change in the offer of services from what suits the provider to what is necessary to reach the intended beneficiaries. A stronger Mayan focus requires an understanding of the history, fears and values of rural Mayan families. Guatemala has historically been a highly divided society. The 1996 Peace Accords recognize the rights of

the indigenous population to control their own development and to interact in their own languages in all official dealings. Although USAID and its partners have a long history of assistance to indigenous populations through a variety of development programs, new methods of program design and implementation will be required to meet the spirit of the Accords, i.e., to contribute to the empowerment of indigenous groups rather than "providing assistance" to them.

Gender focus: A gender focus means that providers are aware that women do not act as sole

[1] According to a 1/16/01 report, nationwide SIAS has service delivery (or PSS) agreements with 72 NGOs to provide services (46 certified and 26 conditional).

agents in rural Guatemala, but rather their relationships with men influence their liberty to act on their own or their children's behalf. A gender focus should include both men and women in activities with the goal of improving family health.

Community problem-solving focus: Community participation in women's and children's health problem solving (e.g., improving access and availability of services, improving knowledge, improving quality of care and identifying harmful, myths, beliefs, and practices and enhancing accurate health knowledge) is critical to improving knowledge and sustaining behavioral change in health care. The aim in community problem solving is to enhance community participation in, and responsibility for, improving community health. USAID/G and its partners will need to provide technical assistance to community groups in using participatory methodologies for problem solving, in designing, implementing, monitoring and evaluating community based health care programs to improve knowledge and strengthen positive health behaviors in the community, as well community surveillance plans for the local monitoring of key indicators of performance.

Focus on improved quality of and access to services: Most Guatemalan women and children have limited access to health services. Furthermore, the low rates of service utilization also suggest that the services that are being provided are not what the public wants. Most of the health providers do not recognize the needs of women and children for integrated health care. As a result there are many "lost opportunities" to provide necessary health care services to women and children. In addition, this lack of integrated service makes health services inaccessible to the rural population. The focus on improved quality of and access to services is critical to the successful expansion of coverage of services. The aim is to strengthen and sustain the capacity of partners to provide quality women and children's health services at the household, community and facility levels. USAID/G has financed the development of innovative new strategies to improve access to and quality of integrated health services. Many of these pilot efforts could be scaled up over the next 3 years.

B. Clients and Geographic Focus

Although the activities carried out under this program will benefit all family members, the primary target populations consist of women of reproductive age and children under five years living in the seven priority Departments of San Marcos, Totonicapán, Sololá, Quetzaltenango, Chimaltenango, Quiché and Huehuetenango. A secondary target population is adolescents.

The specific geographic areas selected should be determined through an analysis of needs and costs. That is, a balance needs to be struck between providing services to a large number of people in a semi-rural area and a small number of people in a remote area. Cost-effectiveness should be one of the selection criteria.

C. USAID's Key Partners

USAID's principle partners in implementing the health sector strategy are described below. The Recipient of this Cooperative Agreement is expected to develop strategic alliances with these partners as well as other donors and organizations supporting RCH services in rural Guatemala.

Ministry of Health/IGSS: USAID supports both the Ministry of Health and the Guatemalan Social Security Institute to improve their capacity to provide reproductive and child health services (using the integrated management of childhood illnesses approach – IMCI). USAID targets its assistance to the MOH in the aforementioned priority departments. USAID assistance to IGSS is for reproductive and child health programs in selected hospitals in the country.

APROFAM: USAID supports APROFAM (the local IPPF affiliate in Guatemala) to: 1) improve the quality and coverage of its rural community health program by strengthening its network of over 3,700 community health workers; and 2) enhancing the quality and sustainability of a national network of 28 clinics and 14 *Unidades Minimas* (health posts) offering reproductive health and other high priority RCH services. **Management Sciences for Health** is assisting APROFAM in achieving these objectives by providing technical assistance and training, particularly in management.

Calidad en Salud: This project is the vehicle whereby training, technical and financial support to the Ministry of Health and IGSS is channeled. *Calidad* is managed by the University Research Corporation (URC), in cooperation with its major subcontractors, the Population Council, EngenderHealth, JHPIEGO and Johns Hopkins University/Center for Communication Programs. URC has been tasked with analyzing options for a contraceptive logistics system for the NGOs to be supported under this Cooperative Agreement.

Maternal and Neonatal Health (JHPIEGO): In Guatemala, this project works with the MOH at the household, community and clinical levels in an effort to reduce maternal and neonatal mortality. The project focuses on clinical quality of care, TBA training, IEC and referral systems.

POLICY II Project (Futures Group): The POLICY Project in Guatemala seeks to improve the policy environment for reproductive health through advocacy activities and improved use of demographic data in planning and policy development. Reducing medical barriers is also an area of focus for the POLICY Project.

FRONTIERS (Population Council): FRONTIERS conducts operations research in Guatemala to test solutions to service delivery problems in the delivery of reproductive health. FRONTIERS conducts studies with both the public sector and APROFAM.

DELIVER (John Snow Inc.): DELIVER works with the public and private sector partners of USAID by providing technical assistance in contraceptive forecasting and security. DELIVER also helps prepare the contraceptive orders on behalf of the Mission each year.

III. PURPOSE AND OBJECTIVES OF THIS COOPERATIVE AGREEMENT

A. Objectives

The purpose of this Cooperative Agreement is to further contribute to the successful achievement of the Strategic Objective *Better Health for Women and Children*. The recipient is expected to achieve the objectives listed below, emphasizing the strengthening of SIAS. By accomplishing these objectives, it is expected that the recipient will contribute to achieving the Intermediate Results and Lower-level Results shown in Figure 1 on page 2.

1. **Strengthen current NGOs**. The Mission expects this project to build upon the work done to date by the Population Council, PCI and SIAS programs to further strengthen the NGOs that are currently being supported by these three mechanisms. The objective is to strengthen each NGO's capacity, particular the SIAS NGOs, to provide quality RCH services, to manage its program effectively and to ensure its sustainability. For a listing of these NGOs, see Annex B.

2. **Create new NGO networks**. Rather than supporting individual NGOs, USAID envisions channeling its support through networks of NGOs, especially networks of SIAS NGOs, to achieve greater coverage and to reduce the management burden on the Recipient and USAID. At the moment there are only three networks of NGOs working in RCH, each of which is being supported by the Population Council. These are SHARE Guatemala (6 NGOs), ASECSA (4 NGOs) and Renacimiento (6 NGOs). The remaining NGOs are not part of any RCH network to USAID's knowledge. The SIAS NGOs appear to be interested in forming networks at the Department/Area level (roughly five networks of 5-7 NGOs each). If these, or other new networks, have not been formalized by the start of this new project, then the CA would want to help them do so as soon as possible so that they could receive immediate assistance.

3. **Encourage the creation of one or more umbrella networks.** Over the life of the project, but as soon as the NGOs are ready, the CA should seek the opportunity to help the current PC, PCI and SIAS networks to form an umbrella "RCH Network" that would represent all (or most) of the NGO members. Initially, this might be made up of a network of PC NGOs and another network of PCI NGOs. Over time this network could be expanded to include other NGO networks, including other SIAS networks. It should be clear that this is a desirable outcome, not a requirement.

4. **Expand geographic and service coverage**. Subject to the availability of funds, the project should seek to expand coverage in two ways. First, by expanding geographic coverage to rural areas where no RHC services are currently available. Second, by expanding the service package to include as many of the priority RCH services as possible. The strategies for expansion should be based on cost-effectiveness criteria, among others.

   For the purposes of the USAID strategy, "RCH services" should include as many of the services listed below as possible. NGOs could provide these services directly or in collaboration with the MOH, IGSS, APROFAM or other NGOs. For example, an NGO might refer women to APROFAM for mammography and cytology screening. NGOs might mobilize children for MOH immunization campaigns. Some NGOs may only be able to provide a subset of services at first but might add other services as capability and funds allow.

   Reproductive Health
   - Prenatal and postnatal care, including tetanus toxoid, iron supplements, folic acid, and identification and referral of high-risk pregnancies
   - Breastfeeding and infant nutrition
   - Family planning services (promotion and service delivery)
   - Detection and referral for breast cancer
   - Screening and referral for cervical cancer
   - Prevention and referral for STDs, HIV/AIDS

   Note: The Mission plans to continue donating oral contraceptives, condoms and IUDs to the NGOs currently receiving them through the Population Council and PCI and is planning to initiate donations of these same commodities to the SIAS NGOs. The management of these donations will not be the responsibility of the Recipient of this Cooperative Agreement.

   Child Health (incorporating the clinical and community IMCI protocols)
   - Diagnosis and treatment of diarrheal disease (including ORT) for children <5
   - Prevention, detection, case management and referral of ARI for children <5
   - Vaccination coverage of children <5
   - Growth monitoring and micronutrient supplementation (Vitamin A and iron) for children <2

5. **Promote NGO-NGO training and technical assistance**. Many of the PC and PCI NGOs have received a significant amount of technical assistance and training. Some of these are now willing and able to provide assistance to other NGOs. This assistance could take various forms. For example, training of new NGO partners in various RCH services and training of partner NGOs in innovative approaches that some NGOs have developed. For

example, two NGOs have adapted the IMCI methodology to the community level. Another has perfected an "*autodiagnóstico*" that it could teach to other interested NGOs. Some NGOs that have strong administrative skills could help other NGOs to strengthen their systems. Of course, most NGOs would need to develop training and TA skills to do this well.

6. **Incorporate Family Planning and IMCI protocols into service delivery.** Many NGOs have added FP to their services as a result of the current program. Others need to do the same, especially the SIAS NGOs. APROFAM and PC have appropriate training and IEC materials that could be used in this new program. The IMCI modules developed for clinical and community levels should be incorporated into NGO service delivery systems. The MOH trainers could train NGO staff in the use of national IMCI modules while NGOs that were involved in the development of community-based IMCI could help train other NGOs.

7. **Strengthen MOH-NGO coordination**. Relationships between the MOH and NGOs are weak at best. It will be very important to find ways to build trust and respect among the MOH and NGOs at all levels (central, department and district) so that they learn to work together toward their common health goals. The CA can help by sponsoring sensitization activities, promoting coordination mechanisms and, in particular, encouraging collaboration at the district level in planning, training, problem-solving and so forth.

8. **Design and implement a MOH-NGO collaboration model**. This model could be undertaken in one department to demonstrate effective coordination and collaboration among district health offices, SIAS NGOs, APROFAM and PC/PCI NGOs to expand coverage or quality services while also improving management functions. If effective, the model could be expanded to other departments.

9. **Assist NGOs to sustain their RCH services**. Most of the PC/PCI NGOs have built sustainability into their plans. This needs to be accelerated to ensure that the RCH NGOs, including SIAS NGOs, and the networks will be able to continue their work after USAID support ends. The CA can provide assistance in sustainability analyses and the development of sustainability strategies and plans as well as provide seed funds to help NGOs and their networks develop revenue-generating activities.

B. Specific Desired Results

USAID will provide assistance to the Recipient in support of the achievement of Intermediate Results 1 and 2 of the Results Framework. Specifically, the Recipient will contribute to the achievement of the two Intermediate Results and associated Lower-level Results shown in Figure 1 on page 2. This Cooperative Agreement will be funded with approximately 50% child survival funds and 50%

population funds. The Recipient will be expected to follow Agency guidance on the use of these funds.

IV. MONITORING AND EVALUATION

The Applicants should include a proposed Monitoring and Evaluation Plan that contains a set of indicators that will permit continuous measurement of progress toward the accomplishment of each of the objectives and intermediate and lower-level results. End-of-project and annual indicators and targets must be established for the measurement of accomplishments. Data sources and collection methods should be noted for each indicator.

Applicants should also be aware of the Mission's Performance Monitoring Plan (PMP) that is used to measure progress toward achievement of the Mission's health strategic objective (see Annex F). All of the Mission's contracts and Cooperative Agreements share the same basic objectives and contribute in varying ways to the accomplishment of the SO. As the applicant will be expected to contribute to the achievement of many of the results outlined in the PMP and report on data relevant to many of the performance indicators listed therein, applicants should be sure to include the following indicators in their individual proposed Monitoring and Evaluation Plans (with both annual and end-of-project targets), in addition to other indicators:

- couple-years of protection (CYP)
- new users of family planning services
- immunization coverage

V. SUBSTANTIAL INVOLVEMENT UNDERSTANDING

USAID/G-CAP will participate in activities under this Agreement in the following manner:

1) Approval of no more than five proposed **key personnel**, one of which will be the Project Director.

2) Approval of **annual workplans** and budget describing all the activities to be funded under the Agreement by both USAID/G-CAP and with counterpart funding. The first workplan must be submitted by the Recipient within 90 days from the signing of the Agreement and cover the period through December 2002. The following two annual workplans shall be submitted by January 15, 2003 and January 15, 2004, for the calendar years 2003 and 2004 (through September 2004 only), respectively. The workplan, which should be prepared based on coordination meetings with USAID/G-CAP and other partners, should include a budget showing the line items shown in the Cooperative Agreement Budget, as well as, individual line items (e.g. salaries, travel, training expenses, etc.). It should also reflect the amount of counterpart contributions to be provided, indicating whether these are cash or in-kind contributions, and what these contributions will cover. Besides a budget, the workplan shall also describe the Recipient's planned activities for the year, including a Timeline with relevant milestones indicated,

and include expected results, tied to the Recipient's Monitoring and Evaluation Plan. Significant changes by the Recipient to approved annual workplans will require additional CTO approval.

3) Approval of a **Monitoring and Evaluation Plan** that will permit ongoing monitoring of progress toward the accomplishment of the Agreement objectives and results (see Section IV of the Program Description for further guidance on the M&E Plan).

4) Any generic (as opposed to specific materials aimed at the clients of a particular NGO) promotional, educational or behavior change oriented materials, otherwise known as "IEC materials", that the Recipient proposes to develop with USAID/G-CAP funds shall be specifically described in the annual workplan or otherwise submitted to the USAID/G-CAP CTO for approval. The purpose of this requirement is to avoid duplication of generic IEC materials by USAID's partners and to allow for such proposed materials to be known and shared by USAID's partners and by the interagency IEC technical working group, chaired by the *Calidad en Salud* Project. The Recipient must also adhere to the Standard Provision concerning "Communication Products", when applicable.

5) Technical concurrence on the **selection of subgrant recipients** and the format and generic content of such subgrants.

ANNEX A: NGO NETWORKS DESIGN

AN ANALYSIS OF DESIGN ISSUES AND A PROPOSED STRATEGY

(POPTECH Project #2000-006: NGO Networks)

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
APROFAM	Guatemalan Family Welfare Association
ASS	*Administradora de Servicios de Salud*
AVSC	Association for Voluntary and Safe Contraception
CA	Cooperating agency or cooperative agreement
CCP/JHU	Center for Communication Programs/Johns Hopkins University
ENSMI	National Survey of Maternal and Infant Health
FP	Family planning
HIV	Human immuno-deficiency virus
IDB	InterAmerican Development Bank
IGSS	Guatemalan Social Security Institute
IMCI	Integrated management of childhood illnesses
IPPF	International Planned Parenthood Federation
IPROFASA	*Importadores de Productos Farmacéuticos*
IR	Intermediate result
JHPIEGO	Johns Hopkins Program in Education in Gynecology and Obstetrics
LLR	Lower-level results
MCH	Maternal and child health
MOH	Ministry of Health
MSH	Management Sciences for Health
MSPAS	Ministry of Public Health and Social Services
NGO	Non-governmental agency
ORT	Oral rehydration therapy
PC	Population Council, "Pop Council"
PCI	Project Concern International
PEC	Programa de Extención de Cobertura
PMP	Project monitoring plan
POPTECH	Population Technical Assistance Project
PSS	*Proveedora de Servicios de Salud*
RCH	Maternal and child care
RFA	Request for application
RH	Reproductive health
RHC	Reproductive and child health
SAS	Health Assistance System
SIAS	Integrated Health Service System
SO	Strategic objective
STD	Sexually-transmitted diseases
TA	Technical assistance
TASC	Technical Assistance Support Contract
URC	University Research Corporation

USAID	U.S. Agency for International Development
USAID/G-CAP	USAID/Guatemala-Central American Programs

I. EXECUTIVE SUMMARY

The purpose of this report is to propose a strategy for a new non-governmental organization (NGO) Networks project that will expand coverage of basic reproductive and child health (RCH) services in seven predominantly Mayan Departments in Guatemala. USAID plans to award a Cooperative Agreement through a competitive process for a three-year period, beginning by October 2001.

Eight project design issues were examined and discussed with USAID and one option was recommended for each issue. The recommendations are:

Create new NGO networks

1. Work only through NGO networks, encourage independent NGOs to join existing networks or form new networks.
2. Work with the NGO networks in the project to form an umbrella NGO RHC network.
3. Have the selected Recipient manage the network at first, with a transition to management by the network itself.

Expand NGO networks

4. Identify NGOs located in the seven priority departments that have experience in providing health or RHC services in rural Mayan areas.
5. Encourage SIAS/PEC[2] NGOs to form networks at the department level and encourage each of these to join the RHC NGO Network.

Strengthen NGOs and NGO Networks

6. Provide training, technical assistance, materials and contraceptives to all member NGOs but provide minimum direct funding for personnel and operating costs only to those non-SIAS NGOs that need such support to be able to provide at least some RCH services.
7. Encourage NGOs to provide training and technical assistance to one another, but assume that this would need to be supplemented with professional assistance.
8. Strengthen MOH-NGO relationships at all levels (central, area, municipal and district) and develop a MOH-NGO collaboration model and test it in one department.

The illustrative strategy that emerges from these recommendations consists of five principal activities:

1. Create NGO RCH networks
2. Expand the NGO RCH network
3. Strengthen MOH-NGO coordination and collaboration
4. Strengthen NGO management and service delivery

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[2] *Sistema Integral de Atención en Salud/ Programa de Extensión de Cobertura*, a government program designed to provide capitation contracts to NGOs that are certified and agree to provide 24 basic services to a defined rural population.

5. Assist NGOs and the NGO network(s) to improve sustainability

The Program Description that results from this strategy addresses the Mission's Strategic Objective 3: *Better Health for Women and Children*, as well as the intermediate and lower-level results that make up the results framework. Applicants are expected to build on the experience and accomplishments of three current NGO initiatives supported by USAID. These are NGO activities of the Population Council (PC), Project Concern International (PCI) and SIAS. Applicants are also expected to develop strategic alliances with USAID's key partners: the Ministry of Health, the Guatemalan Social Security Institute, APROFAM, the *Calidad en Salud* project, the Maternal and Neonatal Health project, the Policy Project, FRONTIERS and DELIVER.

As noted previously, the primary objective of this project is to expand coverage of basic RCH services to indigenous Mayan populations in rural areas. For purposes of this project, "RCH services" should include as many of those listed below as possible, provided directly or in collaboration with the MOH, IGSS, APROFAM or other NGOs:

Reproductive Health

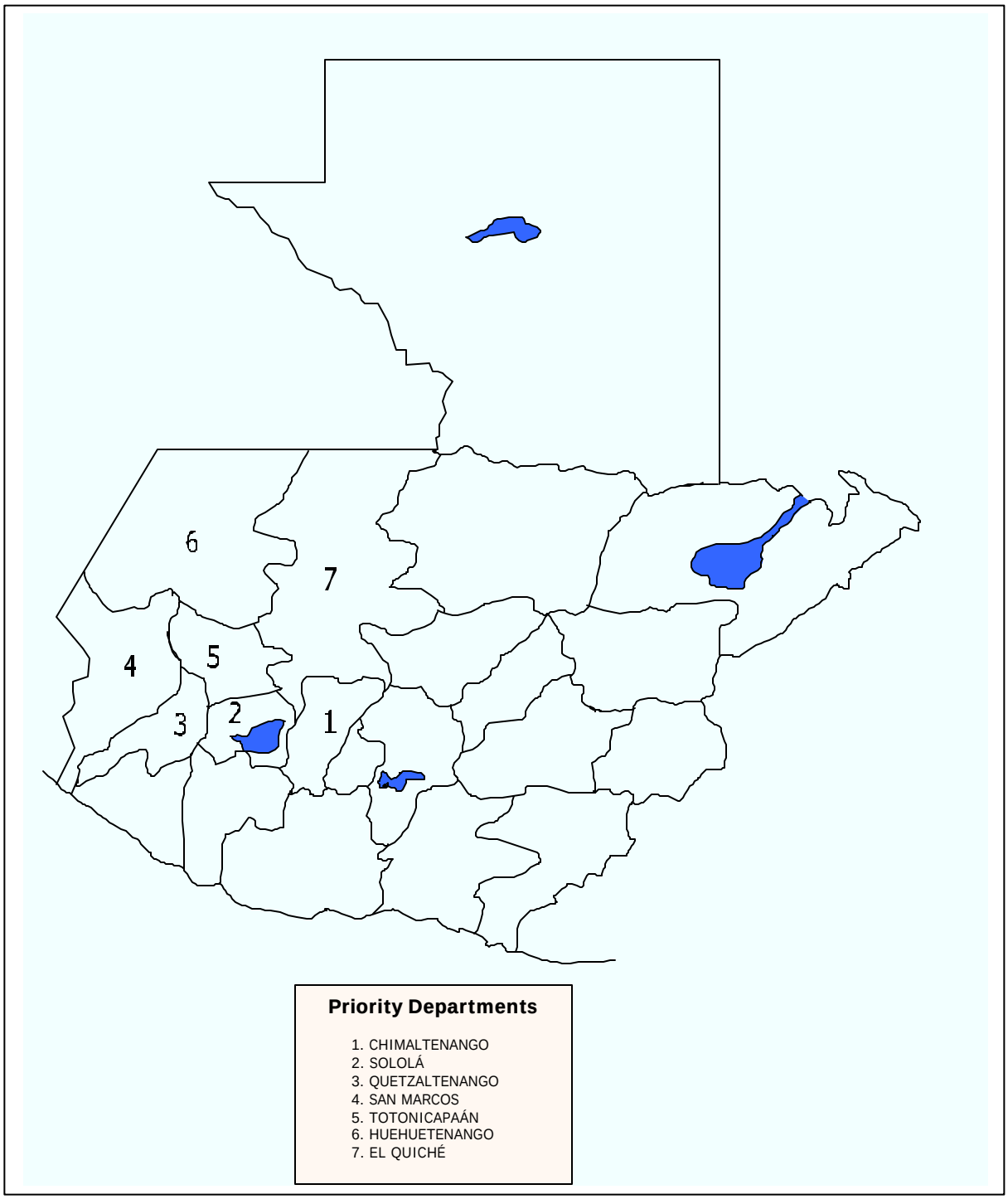
1. Prenatal and postnatal care, including tetanus toxoid, iron supplements, folic acid, and identification and referral of high-risk pregnancies
2. Breast feeding and infant nutrition
3. Family planning services (promotion and service delivery)
4. Detection and referral for breast cancer
5. Screening and referral for cervical cancer
6. Prevention and referral for STDs, HIV/AIDS

Child Health (incorporating the clinical and community IMCI protocols)

7. Diagnosis and treatment of diarrhea disease (including ORT) for children <5
8. Prevention, detection, case management and referral of ARI for children <5
9. Vaccination coverage of children <5
10. Growth monitoring and micronutrient supplementation (Vitamin A and iron) for children <2

Other annexes in the report include a listing of all PC/PCI/SIAS NGOs in the priority departments (B), a brief NGO cost analysis (C), an overview of SIAS/PEC (D), and an overview of *Calidad en Salud* (E).

Figure 2: Guatemala Target Areas for NGO RCH Networks Project



II. INTRODUCTION[3]

A. RCH NGO Networks Project

USAID Guatemala plans to seek a qualified organization to create and strengthen non-governmental organization (NGO) networks. These networks will expand coverage of basic reproductive and child health (RCH) services in seven priority Departments in the Central and Western Highland region of Guatemala. These are the Departments of San Marcos, Totonicapán, Sololá, Quetzaltenango, Chimaltenango, Quiché and Huehuetenango (see Figure 2 on preceding page). The purpose of this program is to increase the use of RCH services by improving their quality, accessibility and management. USAID plans to award a Cooperative Agreement for a period of approximately three years, beginning by October 2001 and continuing through September 2004.

B. Scope of Work and Schedule

The purpose of this consultancy was to assist USAID Guatemala in the design of this new project. Specifically, the product was to be a report containing a Program Description that the Mission could incorporate in an RFA that will result in the award of a Cooperative Agreement, through a competitive process to an organization to implement an RCH NGO Networks project.

A two-person team was recruited by POPTECH to carry out the assignment in a 2-½ week period between January 15-31, 2001. The team members were:

> Jack Reynolds, Ph.D., Team Leader, whose expertise is in program design and evaluation, particularly in Reproductive Health, Primary Health Care, Family Planning, and Maternal and Child Health, particularly in Latin America and Southeast Asia; and
>
> Elizabeth Burleigh, Ph.D., whose expertise includes, NGOs, networks, health sector reform, policy and strategy development, program implementation and community-based primary care, largely in Latin America and especially in Guatemala and El Salvador.

The team spent most of its first week in Guatemala City reviewing documents and interviewing various staff from USAID, the MOH, CAs and NGOs. A one-half day meeting was held in Chimaltenango with all of the NGO directors supported by the Population Council's cooperative agreement. The first three days of the second week were spent in the field. The team went to four of the seven target Departments, visited seven NGOs and several APROFAM clinics and *Unidades Mínimas*. Interviews were also conducted with MOH Area and MOH District staff as well as a SIAS NGO. The remaining time was spent drafting this report. Several meetings were held with USAID to discuss issues and design options before the first draft was submitted January 29. The draft was reviewed by USAID,

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[3] For background information on the health situation in Guatemala, USAID's Strategic Objective and NGO activities in the target Departments see the Background section of the Program Description.

revised and the final version submitted to USAID January 31.

C. Organization of the Report

The Program Description is the principal product of this assignment. The rationale for the Program Description makes up the body of the report. Critical design issues are presented and discussed in the following section (III: Issues). Each issue includes two or more options whose advantages and disadvantages are highlighted. The options recommended by the team form the elements of a proposed strategy (IV: Proposed Strategy).

The remainder of the report consists of annexes that might provide useful information to USAID and interested applicants. These include a listing of NGOs supported by USAID and SIAS; an overview of SIAS/PEC; an overview of the USAID-supported project known locally as *Calidad en Salud*, which provides technical assistance and training to SIAS, its NGOs and IGSS. A brief cost analysis is also included to give USAID and Applicants an idea of the magnitude of current support costs for NGOs. This analysis is limited to the Population Council's 23 NGOs.

Readers should understand that all of this material reflects the views of the team. Although there have been several in-depth discussions with USAID, the recommended options and proposed strategy do not necessarily reflect the views of USAID.

III. ISSUES

A. Creating NGO Networks

Issue 1: Work with individual NGOs or networks.

Statement: Should the NGO RCH Network Project work directly with individual NGOs or only with NGO networks?

Discussion: There are many NGOs working in health in the central and western highlands. Some of these are within existing networks, and some are not. Some of those that are not in networks may be in the MOH SIAS program, while others may be strong in health but have decided to work alone rather than join a group. In addition, there are networks of NGOs in the seven priority departments that are within networks currently supported by USAID through the Population Council, and other NGO networks that work in health but are not receiving USAID support. This situation presents the new NGO RCH Network Project with several options for project organization and management.

Option 1: **Work only through NGO networks, encouraging independent NGOs to join existing networks or form new networks**. The advantage to this approach is that the management units for the project would be reduced while the number of NGOs could be increased, thereby increasing project coverage. The drawback is that this approach might leave out some individual health NGOs that have wide coverage and are strong institutions, but which do not belong to any group. Some of these NGOs

are within the current PC and PCI NGO projects funded by USAID. However, both the PC and PCI NGOs have indicated that they are ready to form their own networks. If they did this, then none of the 30 NGOs in the current project would be left out.

Option 2: **Work with both NGO networks and individual NGOs and encourage independent NGOs to join existing networks or form new ones**. This would increase the management burden for the project, but would also allow the project to work with any strong individual health NGO that may want to be involved. There may be very strong NGOs working in health that do not belong to or want to join an existing NGO network. NGOs are often very independent and wary of being placed "under" another NGO. However, the CA would have to put a cap on the number of individual NGOs it could manage.

Recommendation: The team recommends that the NGO RCH project take the first approach: **work only through NGO networks, encouraging independent NGOs to join existing networks or form new networks**. This option reduces the management burden and does not need to exclude any of the current PC and PCI NGOs. That is because the term "network" should include not only formal NGO networks with legal status, but also informal NGO networks. All types of networks, including informal SIAS networks, could receive training, TA, materials and commodities. However, sub-grant funding would need to be limited to those NGO networks that have legal status and a formalized financial structure for grant management.

Issue 2: Creating an umbrella NGO RCH network

Statement: Should the NGO RCH Network Project form an overall RCH network?

Discussion: The management burden of working with a number of separate NGO networks is much greater for the CA than working with one umbrella network. There should be economies of scale, as well, with an umbrella network. However, the NGOs may not want to give up their independence to join an umbrella network. NGOs often mistrust large organizations and the proposed umbrella could be seen as a threat. On the other hand, big networks provide a larger range of experience that is often a compelling reason to join any network. The many NGOs in the highlands working in health have little contact with one another unless they are in an existing network or working on a project that brings them together. Most express the need to coordinate more with other NGOs and learn from one another's experiences, however few take the initiative to make this actually come about. This lack of coordination and communication among NGOs results in duplication of effort (particularly in the development of materials, modules and approaches), overlapping programs on the community level, mixed messages and approaches given to households, and NGOs that lack up-to-date technical information on RCH. NGOs whose health programs are not well thought out or up-to-date may suffer from community disinterest or lack of respect from other NGOs and the public sector.

Option 1: **Work with separate NGOs networks without creating an umbrella network.** Under this option, the project would identify the strengths and weaknesses of each NGO network and then

provide the necessary strengthening through each network. The CA would enter into grant agreements with formal networks but would have to provide individual training, TA, etc. to the individual members of the informal networks, such as those NGOs in an informal SIAS network. This option involves a significant management burden for the CA.

Option 2: **Work with the NGO networks in the project to form an umbrella NGO RCH network.** This would significantly reduce the management burden for the CA since the umbrella network would be responsible for entering into agreements with the formal networks and providing training, TA, etc., to the individual members of the informal networks. However, it could take many months to put the umbrella network together. For example, the CA would need to bring the various networks and their members together to reach consensus on going ahead with the idea. At some point in the project, the network would be formalized into a legal NGO RCH network so that it would be officially recognized by the government and USAID. It would need this legal status in order to enter into grants, agreements and contracts with these institutions. A variation of this option would be to set up more than one umbrella. This might be an attractive alternative if some NGOs would rather have their own umbrella. The SIAS NGOs, for example, may eventually prefer to have a SIAS umbrella. This would still reduce the management burden.

Recommendation: The team recommends option 2: **work with the NGO networks in the project to form an umbrella NGO RCH network.** Both the PC and PCI NGOs (and at least one group of SIAS NGOs) are ready to set up their own networks. This may be a good time to bring up the idea of consolidation into one umbrella network. This option not only has the advantages of a reduced management burden for the CA and USAID; it also turns over responsibility for the growth and sustainability of the network to the NGOs themselves. The CA should probably discuss this idea with the various NGO networks and their members right from the beginning and make it clear that it will be up to them to decide if and when they are ready to set up one or more umbrellas. Once they decide to go ahead, the CA would work with the network members to formalize it. Over time, other health networks could apply for membership.

Both the CA and USAID should understand that the NGOs may not agree to set up an umbrella. Thus, this should be viewed as a desirable outcome, not a requirement.

Issue 3: Management of an umbrella NGO RCH network

Statement. Obviously, this issue is only relevant if the NGOs agree to set up one or more umbrella networks. If they do, then the question is: How should an umbrella RCH NGO network be managed or structured? At what point in the project should it be formed?

Discussion: There are several ways in which NGO networks can be managed. NGOs may come together and elect officers, but decide to keep the network informal and not seek legal status or establish offices. NGOs that have worked together for some time may decide to formalize their relationship. When this occurs, they generally select one of the members of the group as the head of the network or set up a new network office. In some cases, networks are set up at the beginning of a project by the donor or CA. In other cases they are set up at the end of a project as a sort of "exit

strategy" to help ensure that project activities continue.

Option 1: **Management by the CA at first, with a transition to management by the network itself**. This approach allows the CA to carry out project activities with the various NGOs and NGO networks that already exist while the network concept is being debated by the NGOs. When and if the NGOs agree to set up an umbrella network, the CA would still be able to carry out project activities while overseeing its development. Once the network is formally established, the CA would gradually turn management responsibilities over to the leadership of the network. An advantage of this approach is that it empowers the NGOs. They decide if and when an umbrella network will be established and who and how it will be managed. That enhances commitment to and the sustainability of the network. Two potential disadvantages are: 1) the NGOs may take a long time to make this decision; and 2) they may decide not to establish an umbrella network. Both waste time and money.

Option 2: **Management from the beginning by an experienced NGO**. This approach involves selection of an existing NGO with network management experience. Participation in the project would be conditioned on working through the network. Although this may rankle some NGOs at the beginning, the expectation is that they will gradually assume ownership of the network. A drawback to this approach is that the CA is once removed from the NGOs in the project and, therefore, depends upon the coordinating NGO to take responsibility for NGO relations. The selected NGOs and networks also have to agree that they will work under the NGO coordinator, which must be one that is respected by all of the organizations. The chief advantage of this approach is that the RCH network is formed from the beginning of the project, with its coordination mechanism in place. That should make it much more efficient than Option 1.

Option 3: **Set up the network and management entity at the end of the project.** This is an "exit strategy" approach that is supposed to ensure that there is some continuity after USAID support ends. The CA is in charge of the project from beginning to end, so there is no mid-term change of management, as in Option 1. In addition, the CA and USAID have the entire project duration to assess various candidates and mechanisms for the network. The major disadvantage is that the NGOs have little time to "buy into" the network, which can jeopardize continuity and sustainability.

Recommendation: The team recommends Option 1: **management by the CA at first, with a transition to management by the network itself**. Once the network is formalized, the CA would gradually turn over management of the project to the designated network manager. The CA could continue to provide assistance and support to the umbrella network, the member networks and individual NGOs, as needed. It will be important to allow enough time for the NGOs themselves to see the advantages of this approach and to consider who they would be comfortable with as the manager.

B. Expanding NGO Networks

Issue 4: NGO and NGO network selection criteria

Statement: What are the key criteria that should be used in selecting NGOs and NGO networks?

Discussion: One of the principal objectives of the project is to expand coverage. One way to do this is to add more NGOs/NGO networks to the project. There are many NGOs working in the central and western highlands of Guatemala to choose from. However, they vary widely in the technical areas of RCH and in their organizational strength and ability to deliver services. For example, some work in the target areas and understand the local cultures. However, they may have little or no health experience. Some others have health experience but have no experience with the Mayan population. Which of these NGOs should the NGO RCH Network Project work with, and what other criteria are important to take into account when selecting NGOs? Because the CA will only be working with networks, an individual NGO that wants to enroll will have to join or form a network to be eligible.

Option 1: **Identify NGOs working in high-risk areas irrespective of their prior experience or institutional capacities.** An advantage of this approach is that these NGOs are already in the area and they understand local customs, beliefs, language and so forth. A disadvantage is that the NGO may be so weak and limited in health that the project would have to invest tremendous resources and time to bring the organization up to speed. This investment might take time and funds that could be spent on other project activities and, therefore, may limit the total number of NGOs the project could afford to enroll. It may also limit project coverage, since small, inexperienced NGOs generally cover only a small population.

Option 2: **Identify NGOs located in the seven priority departments that have experience in providing health or RCH services in rural Mayan areas**. Ideally, the best candidates would also have adequate management skills. The advantage of this approach is that the project would be able to start, not from scratch, but from a position of relative strength with organizations that already know how to deliver health services to indigenous communities. They may only need assistance in supplementing their service package to include family planning or IMCI, for example. This also requires a much smaller investment than Option 1 and ensures a much quicker start-up of service delivery. A potential disadvantage is that these NGOs or networks may not be located in the target areas and would have to spend time and money getting themselves established in new communities.

Recommendation: The team recommends Option 2: I**dentify NGOs located in the seven priority departments that have experience in providing health or RCH services in rural Mayan areas.** Where possible, priority should be given to selecting NGOs with RCH experience over those with general health experience. Of course, it should be clear that the number of NGOs and networks that can be included will depend on available resources and the resource requirements of each prospective new member.

The team also recommends that the CA develop a list of other relevant criteria for selection of new NGOs. The following is an illustrative list:

- Legal status (*personería jurídica)*
- Experience in the provision of one or several RCH services, preferably in rural areas
- Professional technical health staff available for supervision (doctor, nurse or auxiliary nurse)
- Community volunteers already working in health (preferably such volunteers as facilitators, *vigilantes*, health promoters or *comadronas*)

- Field staff who speak the local languages fluently
- Transport already available (at least a vehicle for supervision)
- Adequate management systems for planning, budgeting, monitoring, logistics, accounting, and so forth.
- Presence in the department and either already working in a high risk area, or willing to expand coverage

Issue 5: SIAS NGO networks

Statement: Should a SIAS NGO network be established?

Discussion: There are approximately 36 SIAS NGOs working in the seven target departments.[4] A priority objective of this project is to create a network of SIAS NGOs and link them to the project. USAID believes that such a network would have great potential for expanding RCH services. It is willing to provide needed technical support to such a network to strengthen the service delivery and management capabilities of the member NGOs. Interviews with a few SIAS-funded NGOs have revealed that they feel that they have much in common and would like to begin to work more closely with the USAID-funded NGOs to share approaches, methods and materials and strengthen their service delivery. The question is, what is the best organizational alternative to bring this about?

Option 1: **Enroll individual SIAS NGOs into one of the existing networks.** This approach could strain the CA's management capacity if all of the 36 SIAS NGOs were enrolled individually into the umbrella network. An advantage, however, is that those SIAS NGOs that want to enroll would not have take the extra step of joining an existing network or wait for a SIAS network to form. Some SIAS NGOs might be willing to join the PC or PCI networks, but others are likely to have little in common with them.

Option 2: **Encourage the SIAS NGOs to form their own <u>national</u> network, and encourage this network to join the RCH NGO Network.** This would be an umbrella NGO network, in effect. As such, it would definitely reduce the management burden. The CA would only need to deal with one SIAS NGO representative. In addition, the SIAS network could be informal and still receive training, technical assistance, materials and contraceptives from USAID-supported projects. That is, as long as it does not seek a sub-grant it does not have to have legal standing to receive this kind of support. However, the 36 SIAS NGOs are very diverse and spread out around the seven departments. There is little motivation for them to form a national network at this time and meetings would be time-consuming and expensive. In addition, the SIAS/PEC program is very young and volatile. There is no assurance that the current NGOs will be certified next year. Recently, 13 NGOs were decertified, including three that were PC NGOs. Finally, a national network would likely include all 119 SIAS NGOs, both providers and administrators, who come from all over the country and have very little in common. It would be a costly and cumbersome mechanism to coordinate. Unfortunately, at the present time there is no mechanism within SIAS to bring the SIAS NGOs together.

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[4] The team was told that there may be as many as 52 certified NGOs, however, only 36 could be identified.

Option 3: **Encourage SIAS NGOs to form networks at the <u>departmental</u> level and encourage each of these to join the RCH NGO Network**. Some of the SIAS NGOs in the seven priority departments have begun meeting together at the departmental level. This seems to vary by department, however. Some departments do not have enough NGOs to form a local network. The distribution of the NGOs is shown in Table 2.

The most viable departments for local networks would be Huehuetenango (14 NGOs), San Marcos (7), Quetzaltenango and Quiché (5 each). These may be the best ones to start with. The expected advantage of this approach is that it builds on existing SIAS NGO groups in small areas, requires little travel by the NGOs, and unifies NGOs working in the same geographical area.

Table 2: Status of SIAS/PEC NGO certification by Highland Department

Departments	Certified	Conditional	Total	Decertified
San Marcos	7		**7**	
Totonicapán			**0**	2
Sololá	1	2	**3**	1
Quetzaltenango	2	3	**5**	3
Chimaltenango	1	1	**2**	
Huehuetenango	8	6	**14**	1
Quiché	2	3	**5**	6
Total	**21**	**15**	**36**	**13**
PC NGOs				3
PCI NGOs	3	2	**5**	1

These networks would also seem to be anxious to meet with and coordinate with USAID-funded NGOs in their departments. This would seem to be especially attractive in Quetzaltenango (7 PC/PCI NGOs), Huehuetenango (4) and San Marcos (3).

Recommendation: The team recommends Option 3: **encourage SIAS NGOs to form networks at the departmental level (when there are enough NGOs) and encourage each of these to join the RCH NGO Network**. Huehuetenango and San Marcos would be attractive pilot areas to test this approach. It would not be necessary for these networks to be legal entities if project support is limited to training, TA and commodities. It is also important to note that networking with SIAS NGOs at the departmental level should provide an opportunity to coordinate all RCH services with the local area and district MOH offices. If USAID wants as many of the SIAS NGOs as possible to participate in the project those NGOs that are not part of a departmental SIAS network could have an informal linkage with the closest departmental networks until there are enough NGOs in the department to warrant forming their own network.

C. Strengthening NGOs and NGO Networks

Issue 6: Operating costs for NGOs

Statement: Should the NGO RCH project provide funding to NGOs for staff and operating costs, or only for training, TA, commodities/equipment?

Discussion: All of the participating NGOs (PC/PCI and SIAS) will be eligible for training, technical assistance, materials and contraceptives. Some PC/PCI NGOs will need financing of operating costs in order to continue. This is particularly true for those NGOs that are still in the process of capacity development and consolidation. Given the short time that some of these NGO grants have been operational, they believe that their community volunteers are not yet capable of implementing activities without ongoing support and supervision from the NGOs. They believe that their organizations would be unable to assume the costs of staff and other operating expenses that are currently paid for through the Population Council or PCI. Although most NGOs expressed their commitment to try to continue to assist their communities, if support for staff and operating costs is not provided, most say that they would have to reduce their services. Some would have to close down. On the other hand, USAID would like to use its limited funding to reach additional NGOs and expand coverage, move away from full operational funding and sub-grants to NGOs, and focus efforts on the strengthening of the NGO program under SIAS. Given this situation, should the NGO RCH Network Project consider sub-grant funding to the current PC and PCI NGOs or not?

The new project will have a budget ceiling of around $2 million for each of three years. The team used budget data from the latest Population Council work plan to make some rough cost estimates (see Annex C). The calculations show that the average annual support to the current NGOs was $36,000. Operating costs made up half of that. Cost per capita averaged $2.65/year and $1.36 of that was for operational costs. "Full funding" at $36,000 per NGO per year would amount to $1.08 million per year if all of the current 30 PC/PCI NGOs were included. If support were limited to operational costs, the annual amount would be $630,000. If half of the current NGOs didn't need any support, the cost would be about the same.

USAID wants to use the average SIAS/PEC capitation figures (Q40 = $5.12/per inhabitant per year) as a ceiling for funding of the PC/PCI NGOs that provide the full range of SIAS services.

Interestingly enough, the PC NGOs' cost per capita was about half of SIAS/PEC. The SIAS program pays $51,613 per 10,000 population. The average PC grant was $11,374 per 10,000 population. However, SIAS NGOs are supposed to provide twice the number of services.

Option 1: **Assess the specific needs of each of the NGOs and allow continued funding for staff and other operating costs as needed**. This option would allow the current NGOs to complete the process begun under the previous projects, complete the strengthening and systematization of MHC efforts, and ensure that all of the RCH service elements are provided properly. Not all of the NGOs would require "full funding," since the needs assessment would identify levels of support required. Disadvantages are significant, however. Expansion of coverage would be reduced, support to SIAS NGOs would also have to be limited, since USAID does not have the funds to provide all of the support required. One of the most important concerns of the NGOs and USAID is preserving the progress that has been made to date. If adequate support for operational costs cannot be provided, that progress could be jeopardized.

Option 2: **Limit NGO support to training, TA and some commodities and equipment.** This is USAID's preferred option. It would allow the project to provide support to more NGOs beyond those

currently funded by USAID, including, most importantly, SIAS NGOs. By building capacity and supplying commodities to additional NGOs, USAID believes that it could expand services as well as geographic coverage. The key assumption, which USAID had been assured was true, is that the current NGOs will no longer need financial support after the current project ends. That assumption does not seem to be valid, and the possible implication of reducing support would be a reduction, rather than an increase, in services, coverage and quality.

Option 3: **Provide minimum funding for operational costs and staffing to enable the current NGOs to provide at least some RCH services.** Like Option 1, this would require an assessment of what each NGO would need to provide a subset of RCH services (see pages 9-10 for a listing of priority services). The principal difference between the two options is that this one limits support to a subset of the RCH services, which should reduce the level of operational costs for the NGOs. The primary disadvantage is the same as with Option 1. This option would reduce funds that USAID wishes to invest in other NGOs to expand services and coverage.

Option 4: **Reduce the number of NGOs supported to those that can become self-sufficient in the next three years**. This is a variation of Option 3. Instead of reducing the scope of services, the reduction would be in the number of NGOs supported. This would be a difficult option for all concerned, since some NGOs would lose all support and that would likely lead to reduced services and coverage. However, the strongest NGO programs would be preserved and should continue without further USAID support. Again, funds invested in this support would reduce the amount left for expansion to other NGOs.

Recommendation: The team recommends the third option: **provide training, technical assistance, materials and contraceptives to all member NGOs but provide minimum direct funding for personnel and operating costs only to those non-SIAS NGOs that need such support to be able to provide at least some RCH services.** Although this would reduce funds available for strengthening new NGOs, there would still be some resources available for that. Just as important, all of the current NGOs would be able to provide (and hopefully sustain) the most important RCH services. It would also give current NGOs time to seek other sources of funding to continue providing a larger range of services and/or expanding coverage. Finally, all of the NGOs, including SIAS NGOs, will still be eligible for training, technical assistance, materials and contraceptives. To avoid the appearance of bias, the CA would need to develop a formula for calculating the amount of support that would be given to each NGO. Such a formula could include, for example, population size, distance from health facilities and the number of RHC services that would be provided and sustained after funding ended.

Issue 7: NGO to NGO strengthening

Statement: A key feature of the NGO RCH Network project is NGO-NGO strengthening through training, provision of materials or TA. What are reasonable expectations?

Discussion: Some of the USAID-supported NGOs have experience and skills that they are willing to share with others. A few have actually done that. However, few if any, have developed training and technical assistance skills to design and deliver professional level assistance. This is a maxim that is

often overlooked in "South-to-South" proposals. The Family Planning Coordinating Board of Indonesia, which spearheaded this initiative, and raised significant donor support to implement it, had to look for outside help to learn how to provide technical assistance to others. Can Guatemalan NGOs realistically be expected to become trainers and TA consultants? Those that are large may have training specialists on their staff. Smaller NGOs are less likely to have such resources. Is such expertise necessary? Is there a simple and inexpensive way to attain it? Would partnerships between technical specialists and professional trainers (and TA experts) be a reasonable alternative?

For instance, APROFAM has well-developed training and IEC materials, supervision and reporting systems related to family planning that could be used to train other NGOs. APROFAM also has 36 years of experience and expertise. The PC/PCI NGOs do not have anywhere near that level of expertise or experience. However, they have some important innovations to offer. For example, several NGOs within the current Population Council project participated in the development, field-testing and training of volunteers using new community-based IMCI and *"autodiagnósticos"* methods. Can these NGOs provide training and TA to other NGOs in the new project. What approach should the NGO RCH Network Project take to promote NGO-NGO assistance?

Option 1: **Assume that NGOs are largely competent to provide support to other NGOs**. Although this would not be the case for all of the NGOs, it may apply to some. The CA would need to identify and assess those NGOs that have sufficient competence to provide training, materials or TA to other NGOs. This option would require a systematic assessment, which could indicate the need for significant investments in training/TA capacity development. The tendency that needs to be avoided is to assume that an NGO that has a successful intervention will be able to train others in that intervention. On the other hand, the assessment could find that more NGOs than expected actually have the capability.

Option 2: **Assume that NGOs are only able to provide a limited amount of training, materials or TA to other NGOs that would need to be supplemented with professional assistance**. This option also requires an assessment. In addition, it would consider such options as team training with an experienced trainer or team TA with a seasoned consultant. This could be an expensive alternative, but it could be worthwhile if the NGO plans to provide a lot of training or TA, for example, a standard course in growth monitoring.

Option 3: **Assume that NGOs have little competence and that they should be used as resources in support of professional trainers/TA consultants.** This option is also expensive, but does not require the NGO to develop any training/TA capacity. The professional bears the burden of design, preparation, execution and evaluation. Although it does not help the NGO build a training/TA capability, it avoids the cost of that investment.

Recommendation: The team recommends Option 2: **assume that NGOs are only able to provide a limited amount of training, materials or TA to other NGOs that would need to be supplemented with professional assistance.** This option should probably be combined with Option 3 to allow some flexibility in investment. For example, some NGOs may be able to develop sufficient capability to run some courses with minimal outside assistance but they might require significant

assistance in running more complex programs.

Issue 8: NGO-MOH relations

Statement: How can NGO-MOH relationships be strengthened?

Discussion: The central level of the MOH has developed policies, strategies and a program to subcontract NGOs. While this program is seen by all to be an excellent opportunity to work together to extend basic services, the MOH and NGOs within and outside of SIAS all seem to agree that the MOH structure as well as the SIAS/PEC is very weak. All agree as well that coordination and communication are weak between the MOH and NGOs and that there are no systematic strategies or mechanisms in place at either the central, area or district level to improve the situation. However, the MOH and SIAS cannot be ignored. At some point serious efforts need to be made to improve NGO-MOH relations so that effective collaboration can become a reality. The principal question is how to do that.

Option 1: **Concentrate on building relationships at the district level**. Decentralization and the SIAS program itself show that the key relationships in the future will be at the local level. The MOH plans to shift responsibility for planning and implementing SIAS to the district level. This will force the districts to include NGOs in the management of local health services. This option would focus on strengthening MOH-NGO relations at the district level through advocacy, promotion of joint planning and other means. The advantage would be to get a jump on upcoming decentralization and learn how to promote local-level collaboration. The disadvantage is that some districts may not wish to collaborate unless directed to by higher levels. They may also need technical and financial support from those higher levels, implying that work needs to be done at all levels to ensure that MOH-NGO collaboration is fruitful.

Option 2: **Build relationships at all levels (central, area and district).** This option would not limit support to the district, but would seek ways to develop mechanisms to encourage improved coordination and communication at all levels. As noted above, the districts may not take action without pressure and support from higher authorities. The advantage of this option is that all levels of the MOH would be addressed simultaneously. This should make it easier to establish models, if not standards, of MOH-NGO collaboration. A disadvantage is the extra costs of trying to work at all levels at once.

Option 3: **Wait until SIAS/PEC is established and stable before attempting to build relationships**. It is common knowledge that the SIAS/PEC program has a large number of design and operational problems and that it could take a long time to make the needed revisions (see Annex D). The recent certification process has resulted in some NGOs moving out of SIAS while others move in to take their place. Turnover so far is high. Thirteen SIAS NGOs in the seven priority departments were decertified this year. Working with SIAS can be risky and costly. The MOH is similarly unstable, with frequent changes of key staff. The advantage of this option is that it eliminates these risks while holding the door open for collaboration as soon as the program is stabilized. The project could still work with individual SIAS NGOs and districts that have established healthy working relationships. The disadvantage is that time will be lost, since it could take years for SIAS and the MOH to overcome

current constraints.

Option 4: **Develop a MOH-NGO collaboration model under SIAS and test it in one Department**. Provide a limited amount of funds to run a demonstration/pilot project with SIAS, perhaps in Quetzaltenango or San Marcos where there are a reasonable number of SIAS and PC/PCI NGOs. The funds would be used to test (through controlled trial and error) a comprehensive MOH-NGO service delivery model for possible replication elsewhere. For example, a SIAS NGO, the local district health office and perhaps a PC/PCI NGO would collaborate in assessing needs, planning, implementation and monitoring of a district-wide RCH service delivery system. The expected results would be assessed along the standard indicators of expanded coverage, improved quality and better management.

Recommendation: The team recommends Option 2: **build relationships at all levels (central, area and district)** and Option 4: **develop a MOH-NGO collaboration model under SIAS and test it in one Department.** The project would work closely with the MOH, its partners and the NGOs to bring the public sector and NGOs closer together. This could include the formation of central, departmental-level working groups, joint analyses of local situations, joint planning, review of SIAS methodologies and suggestions for improvement, joint training, unification of service delivery methodologies, joint monitoring and evaluation. This effort should be aimed, not only at improving service delivery, but also at reducing the tension between the two groups and improving the credibility of each in the eyes of the other. It should not be limited to SIAS NGOs but should also include other health NGOs working in the seven priority departments. The "collaborative model" would demonstrate MOH-NGO cooperation in service delivery at the local level.

IV. PROPOSED STRATEGY

The purpose of this Cooperative Agreement is to contribute to the Mission's Strategic Objective 3: *Better Health for Women and Children.* The principal objectives are to enable more rural families to use quality RCH services (IR1) and to ensure that RCH programs are well managed (IR2). The Recipient will contribute to the achievement of these results by: 1) creating one or more new networks of RCH NGOs; and 2) strengthening NGO service delivery and management.

A. Vision

The vision encompassing the strategy is of a strong NGO network complementing a strong MOH/SIAS network that work together to expand coverage of basic RHC services in the seven priority Mayan departments.

B. Strategy

An illustrative strategy is described below. Applicants are encouraged to elaborate on this strategy and/or to propose their own approach. The strategy consists of five principal activities:

1. Create NGO RCH networks
2. Expand the NGO RCH network
3. Strengthen MOH-NGO coordination and collaboration
4. Strengthen NGO management and service delivery
5. Assist NGOs and the NGO network(s) to improve sustainability

1. Create NGO RCH networks[5]

The PC and PCI NGOs have already created informal networks. At least one informal SIAS network has also been created. If these have not been formalized by the start of this new project, then the CA would want to help them do so as soon as possible so that they could receive immediate assistance. Then, over the life of the project, but as soon as the NGOs are ready, the CA would help the current PC, PCI and SIAS networks to form an umbrella "RCH Network" that would represent all (or most) of the NGO members. Initially, this might be made up of a network of PC NGOs and another network of PCI NGOs. Over time this network could be expanded – and/or a second umbrella formed – to include other NGO networks, such as the SIAS networks. It should be clear that the umbrella(s) are desirable outcomes, not requirements, since the NGOs may not agree to this idea.

- **Develop the concept:** e.g., the CA and NGOs (PC/PCI/SIAS) might hold a seminar to work out the concept for an umbrella NGO RCH Network, including its purpose, structure, staffing, funding, operating mechanisms, etc. The outcome might be general agreement on the principles to be elaborated by working groups following a suggested timetable.

- **Set up the network:** e.g., once the NGOs are ready to go ahead, the CA could help selected representatives of the NGOs to establish an informal network at first, which eventually would become a legal entity that would be recognized by the government and USAID. This process, which could take quite a while to complete, might include processing the required legal documents, setting up an approved structure, securing the needed resources, documenting the principal operating procedures, and so forth.

- **Transfer management :** if an umbrella is established, then the CA might initially act as the "manager" of the informal network while it is being formalized. At an appropriate time a phasing plan might be developed whereby the CA gradually turns over various coordination and management tasks to the NGO that the members select as manager. When the transfer is complete, the CA would remain on as the technical consultant to the network for the remainder of the project.

2. Expand the NGO RCH network

The CA would help the network to develop criteria and selection procedures for the expansion of the network.

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[5] Some NGOs and NGO networks may never join. USAID and the CA will need to decide how many small NGO networks they would be willing and able to deal with separately.

- **Identify potential members**: e.g., other members of current networks (e.g., other health NGOs in SHARE); other health networks in the Highland area; and other individual health NGOs (e.g., SIAS NGOs) that could expand coverage;

- **Develop selection criteria**: e.g., coverage potential; current capability in RCH; TA and resource needs; management burden; willingness to collaborate with other members, the MOH and SIAS; and sustainability potential.

- **Develop selection procedures**: e.g., nomination by a member or solicitation of applications; examination by a membership committee; and approval by the network members.

3. Strengthen MOH-NGO coordination and collaboration

The CA would act as a facilitator to help develop positive working relationships among the NGOs and the MOH at all levels (central, area and district). If an umbrella is established, the network directorate would gradually assume this responsibility. Coordination with SIAS and *Calidad en Salud* will be especially important to avoid duplication and gaps.

- **Sponsor sensitization activities**: e.g., the CA might facilitate sensitization seminars, meetings, field visits, etc., to enable NGOs and MOH officials to get to know and trust one another. The PCI NGOs might hold a workshop for some other NGOs to discuss how they have established partnerships with district health officers. The MOH might sponsor field visits to districts where this coordination has taken place.

- **Develop NGO-MOH coordination mechanisms**: e.g., the CA might work with the MOH to set up coordination mechanisms at the central, department and district levels; committees or task forces might be set up to accredit NGO training courses; an NGO network team might do pre-accreditation screening of SIAS/PEC applicants; joint MOH-NGO planning might be promoted at the district level.

- **Design and implement a MOH-NGO collaboration model under SIAS:** e.g, the CA may want to sponsor a pilot project that could demonstrate how the SIAS NGOs, the MOH, APROFAM and the PC/PCI NGOs could work together to expand services in a department, such as San Marcos or Quetzaltenango. This model might emphasize joint planning, implementation and monitoring of district-wide RHC services. If effective, it could be adapted to other departments.

4. Strengthen NGO management and service delivery

A key role of the CA, both before and after the umbrella network is formed, will be to strengthen the management and service delivery of current and new NGOs, especially SIAS NGOs. All of the members will be eligible for training, technical assistance, materials and contraceptives. Some may receive funding for operational costs. Close coordination with SIAS/MOH and *Calidad en Salud* will be needed to avoid duplication.

- **Enroll NGOs:** e.g., the CA will probably want to enroll the NGOs, either as members of formal networks or informal networks. Only those NGO networks that are formal, legal entities could receive funds. Informal networks (those that are not legal entities) could receive assistance, as long as they do not receive funds directly from the CA. The CA, or another legal network, would be responsible for paying for their training, IEC materials, etc. The CA will probably want to canvass each of the NGOs and develop enrollment criteria to ensure that all of the interested NGOs and networks are treated fairly and equally.

- **Develop objectives and results packages:** e.g., the CA will probably want to negotiate results expectations with the various NGO networks. In addition to the required IRs and LLRs, the CA may have other indicators to add, for example, basic RCH coverage indicators. The CA should make sure that the indicators selected are compatible with those of SAS and SIAS.

- **Conduct NGO needs assessment:** the NGOs are in different stages of capacity development. Some may be able to provide the all RCH services right away, some may have a long way to go. Quality is likely to vary significantly among the NGOs. The CA will probably want to assess their needs and set priorities among them. For example, some may need TA and/or training in logistics management, others may not. Some may need contraceptives and other medications. Some may need support for staff, travel and other operating costs. A few may need equipment, even vehicles. The CA will need to identify these needs and determine what can and cannot be supported by the project in a way that is open and fair. For example, the CA could develop a formula for calculating the amount of support that would be provided to each NGO.

- **Identify support modalities:** e.g., in addition to project support from USAID, there are other potential sources that the CA will probably want to identify and enlist to complement project support. For example, some financial and commodity support may be available from other donors, the MOH, and/or IGSS. Training and TA may be available from the MOH, especially for those NGOs that are affiliated with SIAS. An important source of training and technical assistance would be the NGOs themselves. NGO-NGO training, for example, might be used to help new SIAS NGOs learn how to provide basic RCH services or how to use a new technique, such as the *autodiagnóstico* or community-based IMCI.

- **Develop agreements, work plans, budgets and monitoring plans:** e.g., in the first year, the CA will probably need to develop these products for each of the NGO networks, which may, in turn, want to develop sub-agreements with their individual NGO members. For example, if the PC NGOs form a network, the CA's agreement would be with that network, not with the individual NGOs. The lead NGO might want to have sub-agreements with each NGO in the network. In addition, the CA will probably want to help the new RCH Network to set up its own grant management procedures, if necessary.

- **Update needs, agreements and work plans:** e.g., the CA (or the RCH network, if it is established soon enough) will normally be expected to solicit annual workplans for each agreement. Changes may be required if, for example, several NGOs form a network during the

project; funding is curtailed; performance is poor, etc.

5. Assist NGOs and the NGO network(s) to improve sustainability

An essential objective of this project is to make sure that as many NGOs and NGO networks as possible are able to continue their work after USAID support ends. Thus, the CA and NGOs will need to build sustainability into their work plans from the start.

- **Develop NGO accreditation criteria and procedures**: An important potential source of future support for the NGOs and their services is SIAS. Although SIAS/PEC has numerous weaknesses at the moment, it also has great potential for expanding quality services to rural families. The CA can facilitate NGO certification for SIAS in several ways. For example, the network could offer to "pre-certify" members that are interested in applying for SIAS/PEC support. The network could sponsor training/TA to help interested members qualify. This assistance could come from NGOs, from the CA or other sources. The network might also offer to participate in supervision and performance monitoring, especially of those NGOs that are hard to reach.

- **Conduct sustainability analysis**: The CA, and later the network itself, could help NGOs assess their sustainability prospects. For example, which health services are the most important to an individual NGO and how could they be sustained? What would need to be done to ensure that the entire SIAS basic package could be provided over the next 10 years?

- **Develop and update sustainability strategies and plans**: Based on the results of the individual analyses, the CA/network might help the NGOs to develop strategies and plans to sustain their coverage, their services, the quality of care and the resources needed.

- **Identify and test revenue-generating schemes**, e.g., develop a health cooperative that produces textiles for sale by participating NGOs; form women's RCH groups to produce and market indigenous artifacts; develop ecotourism activities (hikes, demonstrations, etc.), marketing health and beauty products to generate funds for health programs.

ANNEX B: NGO DESCRIPTIVE INFORMATION

The following table provides the latest information on NGOs that are providing RCH information and/or services in the target departments under Project Concern International (PCI), the Population Council (PC) and SIAS/PEC. The list of SIAS NGOs tends to change frequently as some NGOs drop out and others are brought in. As of this writing (2/8/2001) we believe that there are about 36 SIAS NGOs working in the seven departments. There may be as many as 52, but we do not have any information about these other NGOs. The list does not include two Pop Council NGOs that work outside the seven departments. These are CPR (in Retalhuleu) and El Recuerdo (in Jalapa).

No.	Affil-iation	NGO	Department	Municipalities	Commu-nities	Total Population	Target Population[6]
Project Concern International							
1	PCI	ATI	Totonicapán	Totonicapán	7	7,735	3,171
2	PCI	CMM	Totonicapán	San Cristobal Totonicapán	9	19,369	7,941
3	PCI	CORSADEC	Quetzaltenango	Olintepeque	7	18,250	7,482
4	PCI	APROSAMI	San Marcos	S. Miguel Ixtahuacán	16	10,656	4,369
5	PCI	ACUALA	Chimaltenango	Patzún	42	26,603	10,908
6	PCI	EB'YAJAW	Huehuetenango	Santa Barbara Chiantla	28 110	19,972 63,000	8,188 13,230
7	PCI	CADECO	Huehuetenango	Barillas S. Mateo Ixtatán	58 95	18,988 30,574	7,785 12,535
8	PCI	ACOMASMI	Huehuetenango	Todos Santos Cuchumatán	22	18,259	7,484
9	PCI	ASCOVIN	Quiché	Ixcán	59	21,452	8,795
Subtotal		9	6	13	343	254,838	91,888
Population Council							
	PC	**ASECSA[7]**	Chimaltenango	NA	NA	NA	NA
10	PC	ADI	Quetzaltenango	Génova	15	710	249
11	PC	CERNE	Chimaltenango	Pochuta	15	500	120
12	PC	Novillero	Sololá	Sta. Lucía Utatlán	4	213	115
13	PC	AMAPROS	Huehuetenango	Todos Santos	19	4,200	1,850
14	PC	**Renacimiento**	Chimaltenango	Patzún	24	25,189	15,327
15	PC	Tinamet Quicotec	Sololá	Argueta	11	4,612	3,155
16	PC	Chuwí Tinamet	Chimaltenango	Comolapa	8	1,372	1,405
17	PC	Candelario	Chimaltenango	Chimaltenango	6	2,630	1,793
18	PC	Kajih Jel	Chimaltenango	Comalapa	13	3,191	2,578
19	PC	Otz'ija María	Chimaltenango	S. José Poaquil	3	1,417	949
	PC	**SHARE**	NA	NA	NA	NA	NA
20	PC	PRODIRAK	Sololá	Nahual	6	7,191	1,415

[6] Children <5 years plus women 15-44 years. PCI estimates based on children <5 = 16.1%; women 15-44 = 21% and infants <1 = 3.9% of the population.

[7] ASECSA and SHARE do not provide services.

			Quetzaltenango	Cantel	3	4,782	905

No.	Affili-ation	NGO	Department	Municipalities	Commu-nities	Total Population	Target Population
21	PC	SINTRAICIM	San Marcos	S. Miguel Ixtahucán	1	5,594	2,644
				S. Pedro Sacatepéqu	2	956	277
				Sipacapa	1	476	138
				Ixtahuacán	10	?	?
22	PC	KASLEN	Chimaltenango	Comalapa	1	1,872	471
				Sinai	1	?	?
				S. Martín Jilotepequ	6	7,962	2,060
23	PC	PRODESKA	Sololá	Sta. Catarina Ixtahuacán	13	5,049	2,074
24	PC	CESERCO	Quetzaltenango	San Carlos Sijí	3	1,335	967
				Cantel	1	840	585
				Cabricán	2	2,604	1,921
			Totonicapán	Momostenango	2	1,280	921
25	PC	ADIPO	San Marcos	Comitancillo	11	3,418	2,421
				San Cristobal	2	759	249
26	PC	Be'lejeb B'atz	Quetzaltenango	San Martín	≥ 8	2,278	4,583
				San Juan Osctuncaclo		2,897	
				San Miguel		2,162	
				La Esperanza		2,488	
				Cantel		2,404	
				El Palmar		2,527	
				Quetzaltenango		4,327	
				Colomba Costa Cuca		2,892	
27	PC	CDRO	Totonicapán	Totonicapán	16	42,307	14,955
				San Bartolo	2	1,241	495
				Momostenango	5	12,099	2,594
				San Francisco	1	2,352	483
				Sta María Ch.	7	19,506	4,740
28	PC	IDEI	Quetzaltenango	San Juan Ostuncalco	3	10,981	5,282
				San Miguel Siguilá	4	6,428	3,252
				Cajolá	5	12,120	6,056
29	PC	PIES de Occidente	Totonicapán	San Andres Xecul	≥ 9	14,097	5,449
				S. Fran. Alto		7,677	2,983
			Quetzaltenango	San Fran la Union		4,255	1,649
				Quetzaltenango		13,046	5,047
				Concepción Chiquirichapa		19,806	7,650
				San Juan Ostuncalco		42,424	16,252
				San Miguel Siguilá		6,098	2,365
				Cajolá		12,877	4,988
						?	?
30	PC	Rxiin Tnamet	Sololá	Santiago Atitlán	13	30,018	12,706
				S. Juan la Laguna	4	6,498	2,739
				S.Maria Visitación	4	1,358	572
Subtotal		21	6	40	≥ 260	376,645	149,429

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31	SIAS	ADSEIC	Chimaltenango	Tecpán Guatemala	1	10,553	4,327
32	SIAS*	Ru Cotzijal Maria	Chimaltenango	S. Martin Jilotepeque	2	16,975	6,960
33	SIAS	Arenys Solidari	Sololá	Nahuala	2	11,721	4,806
				S. Catarina Ixtahuacán	?	?	?

34	SIAS*	ASDHI	Sololá	Sololá	5	32,512	13,330
				Nahualá	?	?	?
				S. Catarina Ixtahuacán	?	?	?
				S. Antonio Palopó	?	?	?

No.	Affili-ation	NGO	Department	Municipios	Communities	Total Population	Target Population
35	SIAS*	Vivamos Mejor	Sololá	Panajachel	3	11,367	4,660
				S. Catarina Palopó	?	?	?
				S. Cruz Laguna	?	?	?
36	SIAS	APICS	Quetzaltenango	Quetzaltenango	1	11,366	4,660
37	SIAS	ADECO	Quetzaltenango	Quetzaltenango	1	11,598	4,755
38	SIAS*	ABC	Quetzaltenango	S. Fran. La Reunión	1	8,321	3,412
				S. Carlos Sija			
39	SIAS*	CEDEC	Quetzaltenango	S. Martín Sacatepequez	2	25,905	10,620
				Conceptión Chiquirchapa	?	?	?
					?	?	?
40	SIAS*	ECOMADI	Quetzaltenango	Hultán	1	11,823	4,847
				Cabricán	?	?	?
41	SIAS	Los Diamantes	San Marcos	Malacatán	1	19,500	7,995
42	SIAS	AASDIMA	San Marcos	Malacatán	4	21,443	8,792
43	SIAS	TXOLJA	San Marcos	Comitancillo	2	18,208	7,465
44	SIAS	ADRIM	San Marcos	Nuevo Progresso	1	23,000	9,430
45	SIAS	PROSACO	San Marcos	Tecún Umán	3	47,212	19,357
				Ocós	?	?	?
				Pajabita	?	?	?
46	SIAS	ACDISEC	San Marcos	Comitancillo III	1	11,798	4,837
47	SIAS	PROSACO	San Marcos	Tajumuico	1	11,000	4,510
48	SIAS	Hoja Blanca	Huehuetenango	Cullco	1	8,000	3,280
49	SIAS	Eb Yajaw	Huehuetenango	S.Sebastian	2	27,847	11,417
				Malacatancito	?	?	?
50	SIAS	Tetzqatanum	Huehuetenango	Aguacatán	2	18,000	7,380
51	SIAS	Kaibil Balam	Huehuetenango	La Democracia	1	12,948	5,309
52	SIAS	Fund. Kanil	Huehuetenango	Concepción Huista	5	70,000	28,700
				Jacaltenango	?	?	?
				La Democracia	?	?	?
				La Libertad	?	?	?
53	SIAS	ADECO	Huehuetenango	Barillas	2	15,349	6,293
54	SIAS	ACODIM	Huehuetenango	Ixtahuacán	1	19,445	7,972
55	SIAS	IMDI	Huehuetenango	Todos Santos	2	22,027	9,031
56	SIAS*	Coop. Esquipulas	Huehuetenango	La Libertad	1	10,800	4,428
57	SIAS*	CEIBA	Huehuetenango	Nentón	1	14,616	5,993
58	SIAS*	SEPRODIC	Huehuetenango	Soloma	1	40,996	16,808
				S.Juan Ixcoy	?	?	?
				Santa Eulalla	?	?	?
59	SIAS*	ASSDIC	Huehuetenango	S. Sebastián Coatán	1	8,000	3,280
60	SIAS*	Ass. S Juan Atitán	Huehuetenango	S. Juan Atitán	1	14,000	5,740
					?	?	?
61	SIAS*	CEIBA	Huehuetenango	Colotengano	1	10,900	4,469
				S. Gaspar Ixchil	?	?	?
62	SIAS	COPINCONUF	Quiché	Chiché	?	?	?
63	SIAS	FUNDADESE	Quiché	Chichicastenango	1	10,607	4,349
64	SIAS*	ASODESPT	Quiché	Zacualpa	1	10,619	4,354
65	SIAS*	ADISA	Quiché	S. Antonio Ilotenango	?	?	?
66	SIAS*	CCAM	Quiché	Chichicastenango	1	10,242	4,199
Subtotal		36	7	47	≥ 79	>628,698	>257,765

SIAS* = conditional approval, to be assessed again in April 2001.

Totals

Affiliation	NGO	Department	Municipal-ities	Communities	Total Population	Target Population
PCI	9	6	13	343	254,838	91,888
PC	21	6	40	≥ 260	≥ 376,645	≥ 149,429
SIAS	21	6	≥ 47	≥ 79	>628,698	>257,765
SIAS*	15	5				
Total**	66	7	≥ 96	≥ 682	1,260,181	499,082

SIAS* = conditional approval, to be assessed again in April 2001.
** Totals for the first three columns less duplication. Last three columns may include some duplication.

Status of SIAS NGO certification by Highland Department

Departments	Certified	Conditional	Total	Decertified
San Marcos	7		**7**	
Totonicapán			**0**	2
Sololá	1	2	**3**	1
Quetzaltenango	2	3	**5**	3
Chimaltenango	1	1	**2**	
Huehuetenango	8	6	**14**	1
Quiché	2	3	**5**	6
Total	**21**	**15**	**36**	**13**
PC NGOs				3
PCI NGOs	3	2	**5**	1

Active PC and PCI NGOs by Highland Department

Departments	PC	PCI	Total
Total NGOs	**21**	**9**	**30**
San Marcos	2	1	**3**
Totonicapán	3	2	**5**
Sololá	5		**5**
Quetzaltenango	6	1	**7**
Chimaltenango	7	1	**8**
Huehuetenango	1	3	**4**
Quiché		1	**1**

ANNEX C: NGO COST ANALYSIS

This specific Annex is included in a separate Excel Document as part of this RFA

Annex D: Overview of SIAS/PEC

In 1997, the GOG embarked on an ambitious effort to extend basic health coverage to impoverished rural and indigenous populations through the contracting of NGOs. The program is known as the *Programa de Extención de Cobertura* or PEC. This program is located in one of the four directorates of the Ministry of Health: SIAS, or the *Sistema Integral de Atención en Salud* (see Figure 3). The SIAS Directorate consists of three departments: Epidemiology, Health Promotion and Education, and Health Service Development. The last department manages the delivery of health services, all the way down through the Health Areas and Hospitals to the Municipal and District Health Offices. This Department has three units, the first of which deals with NGOs.

Under PEC NGOs can apply to be service providers (*Proveedores de Servicios de Salud*, or PSS) or administrators (*Administradores de Servicios de Salud*, or ASS). The difference is that PSS provide services directly to communities. The ASS are middlemen who pay for services delivered by MOH providers. Our main interest is in the PSS. By early 2001, SIAS/PEC had certified 72 NGOs nationwide to provide services, 36 of which are located in USAID's seven priority departments.

Table 3: SIAS NGOs by category, January 2001

NGO	Certified	Conditional	Total
PSS	46	26	72
ASS	29	18	47
Total	75	44	119

Source: SIAS report 1/16/01

The MOH contracts PSS NGOs to deliver a basic package of 24 services in four categories: Maternal Health, Child Health, Communicable Diseases, and Environmental Diseases. The NGO receives capitation payments in quarterly installments to provide services to a "jurisdiction" of about 10,000 people. The capitation fee is 40Q per inhabitant per year (about $5) in addition to vaccines and some essential drugs that are supplied to the NGO by the MOH. The fee is supposed to cover the cost of providing the services as well as administrative expenses.

SIAS has standardized the composition of the NGO health teams (see Figure 4). The standard for a population of 10,000 is: one (full-time, paid) Ambulatory Physician and one (full-time paid) Institutional Facilitator who manage the program and provide medical and educational services respectively; eight (half-time, paid) Community Facilitators who are selected by their communities and work out of their community health centers; and 100 *Vigilantes de salud*, who are volunteers from the communities, each of which is responsible for a "Sector," which consists of about 20 households. In sum, one Institutional Facilitator manages 4 Community Facilitators who manage about 10 *vigilantes* each. The Community Facilitators also work with whatever traditional midwives (*comadrones*) there are in the community as well as any Malaria and Dengue Volunteers. The Community Centers (*Centros de Convergéncia,* or *Centros Comunitarios*) serve as the basic sites for health information and services and usually include a small drug shop (*Botiquin Básico*), both of which are managed and maintained by the community itself.

The effectiveness of the program has not yet been assessed but at least two studies are underway, one by SIAS itself and another through an IDB contract. They should provide useful information,

not only on progress made, but on design and implementation problems that have not yet been examined

systematically. MOH documents note that the main successes so far relate to increased health coverage, especially immunization. Because SIAS is relatively new it is experiencing some problems. Table 4: Composition of the Basic Package of SIAS Services
(as of 2/8/2001)

Maternal Health

- Prenatal care
- Tetanus toxoid
- Iron, folic acid supplementation during pregnancy
- Delivery
- Postpartum care
- Birth spacing (education and referral)
- Detection of cervical and breast cancer
- Detection and referral of emergencies

Child and School Age Health

- Immunizations
- ARI management
- Diarrhea/cholera management
- Vitamin A and iron supplementation
- Growth monitoring (children under 2 yr)
- Detection and referral of emergencies
-

Illness management and emergency care

- Vector control
- Zoonosis control
- Tuberculosis control
- STDs/HIV AIDS control
- Diarrhea and cholera control
- Detection and referral of emergencies

Environmental services

- Water quality monitoring
- Promotion of sanitary disposal of waste
- Improvement of household sanitary conditions
- Food hygiene

•

Criticisms are easy to find, however, and range from complaints about the competence of the NGO providers to the design and management of SIAS itself. Among the most common criticisms are the following.

Design issues

- **Rigidity**: SIAS requires a standard package of services (see Table 4) that PSS are required to provide, unless there is no such health problem in the service area (e.g., malaria, rabies). PSS can provide additional services, but those on the list are the priorities. Some NGOs complain that this list should reflect actual local conditions and needs. The capitation payment is fixed regardless of the location and dispersion of the households; the structure of the health team is fixed and cannot be adjusted to fit local conditions; the certification criteria are fixed and cannot be adjusted to fit local situations. Budget and implementation guidelines are rigid.

- **Capacity**: the design did not take local capacity into account. Many facilitators and vigilantes have limited health knowledge and skills but there is practically no training built into the system (one day/month). The design is based on community volunteers with inadequate technical health support. No technical assistance or supportive supervision built into the program.

- **Communication**: No mechanisms have been built in for MOH-NGO communication; no travel funds are provided for district health staff to visit NGO program sites; no forums have been set up for the interchange of ideas and experiences among SIAS NGOs; there are no feedback mechanisms.

- **Resources**: the design did not take into account the costs of providing continuity of care in rural and remote areas, except to pay higher salaries for the technical staff in those areas. The administrative "overhead" has to cover materials, supervision, fuel, office space, supplies, training as well as basic data collection and processing, financial management, and so forth.

Implementation

- **Certification**. Questions have been raised from the beginning about the transparency of the contracting and certification processes, which, according to an IDB report, have been subject to political pressures. Certification criteria are not consistent with required services; certification appears arbitrary and there is no feedback or any attempt to improve deficiencies.

- **NGO Selection.** The government did not do enough to build trust among and recruit the more qualified NGOs, many of which decided not to participate. As a result, some NGOs were created just to apply for SIAS contracts. They have no health or community experience, yet they are funded. Some other NGOs, which are legitimate, have no health capabilities. Some are unwilling or unable to deliver the required services. There is significant turnover in NGOs, which affects service delivery and continuity.

In spite of these problems both the health NGOs and MOH staff interviewed believe that the program represents a new and important opportunity for the MOH and NGOs to work together, and for communities in remote and rural areas to receive key MCH services that they have never received before. As a result, most agree that an effort needs to be made by both the MOH and NGOs to address these problems and to modify the model to improve its chances of success.

Figure 3: Integrated Health Services System SIAS/PEC

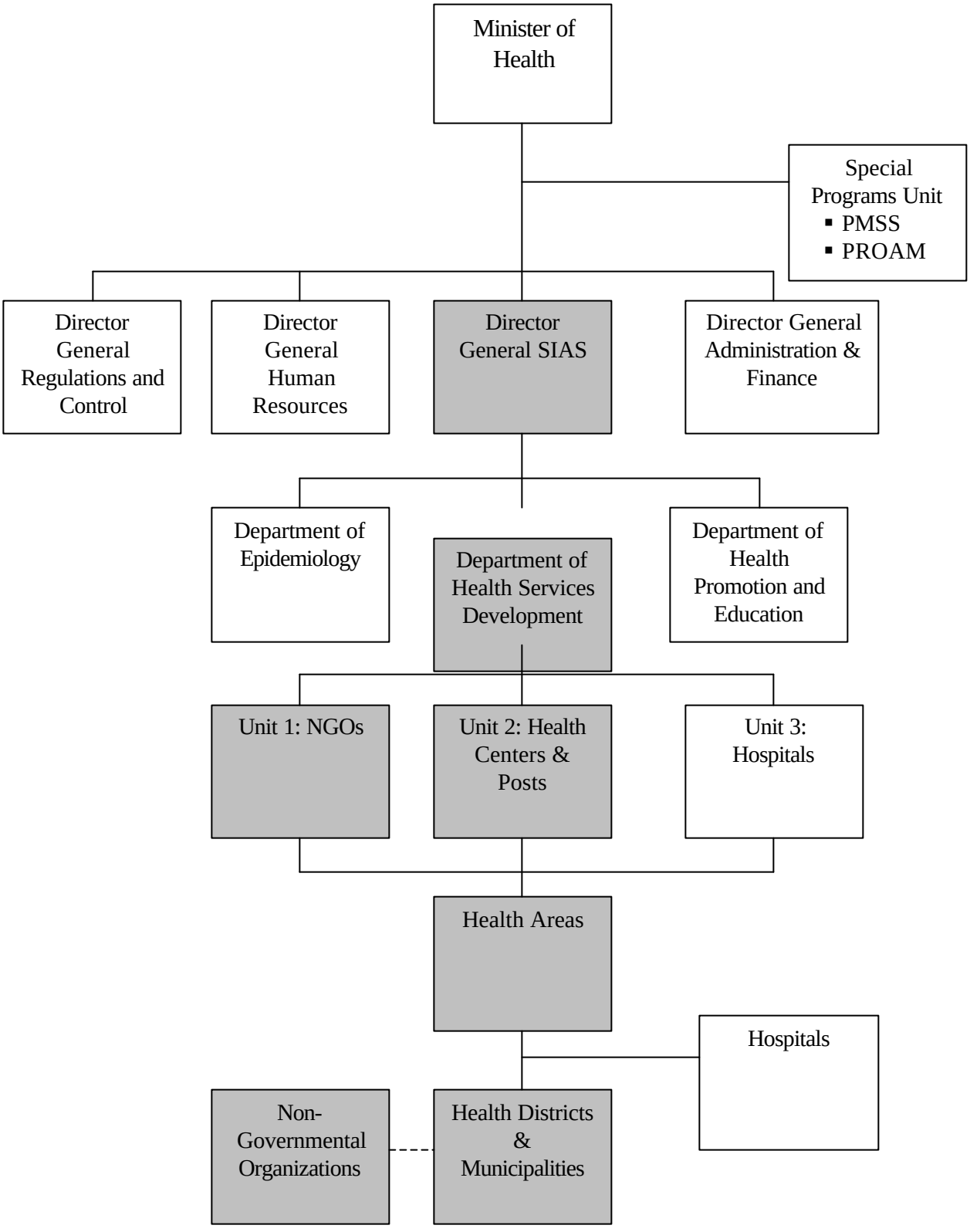
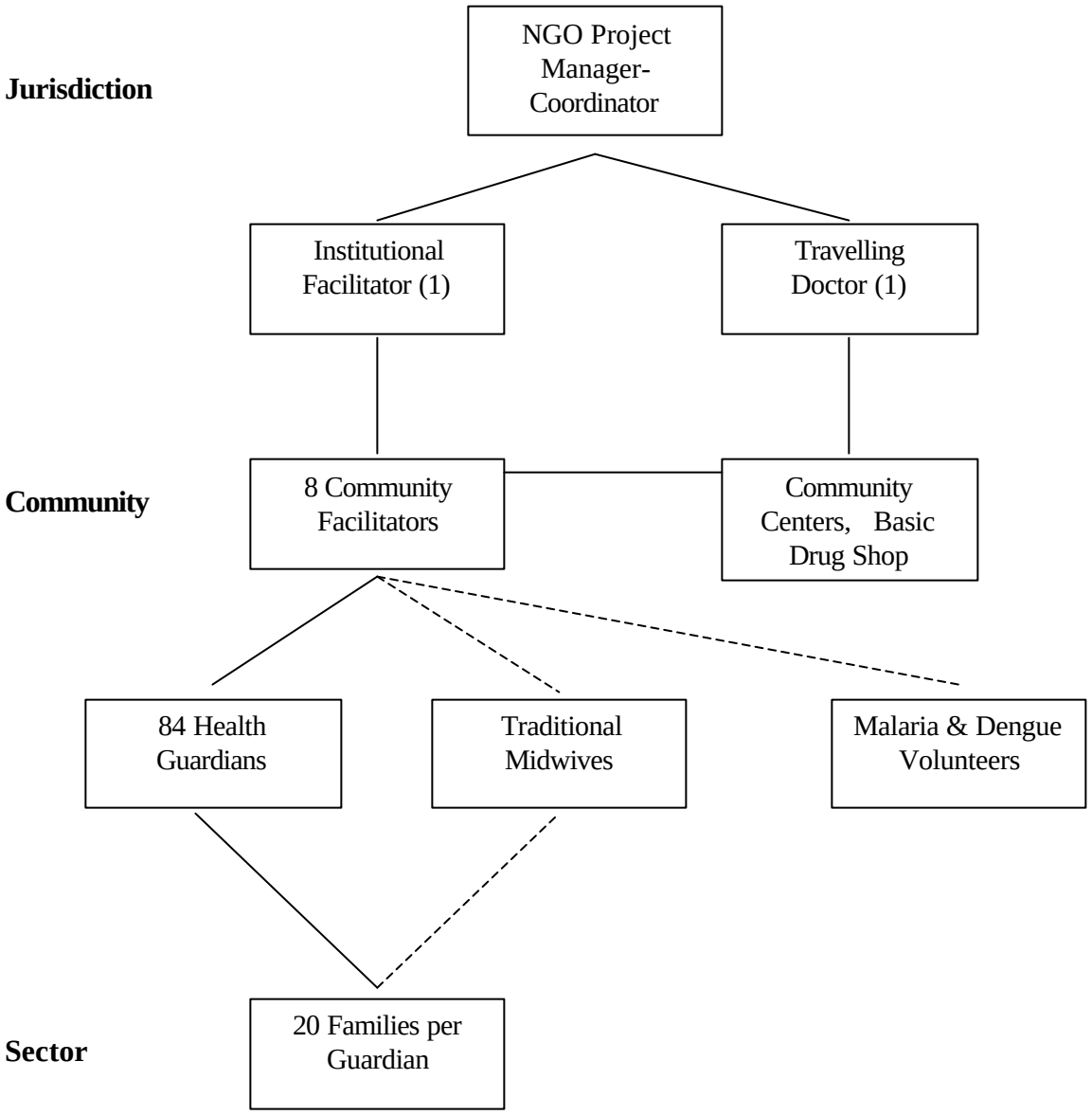


Figure 4:SIAS/NGO Staffing Pattern for a Jurisdiction of 10,000 Population



ANNEX E: OVERVIEW OF *CALIDAD EN SALUD*

This project was designed to strengthen the national health service delivery model, which includes the service systems of the Guatemalan Social Security Institute (IGSS), SIAS and its partner NGOs. A key objective is to provide these institutions with the tools and skills needed to improve the quality of and access to basic RCH services, and to increase demand for and utilization of these services, especially in the seven priority Mayan departments. Family Planning and immunization are to be strengthened nationwide.

USAID awarded a task order under the worldwide TASC to University Research Corporation (URC) in late 1999 to assist the MOH, partner NGOs and IGSS in this effort. Specifically, URC and its subcontractors (AVSC, Population Council, JHPIEGO and CCP/JHU) are to help promote adequate health behaviors at the household level, improve the quality and accessibility of services offered at health facilities and by community health workers (e.g., traditional midwives and promoters), strengthen management systems (including finance, administrative, logistics, monitoring and evaluation systems) and enhance community participation. URC is also to help strengthen selected RCH services in IGSS facilities.

The project is developing clinical training centers in hospitals at the central level and the seven priority departments to train physicians and nurses in voluntary sterilization and IUDs. Similar training centers are being developed for IMCI. Training will cascade down to the district, health post and community levels (for traveling doctors, facilitators and *vigilantes*). It is this lower level that is of most interest to the NGO Networks project.

The *Calidad en Salud* project has updated service standards and training materials, but it does not have enough funds to provide comprehensive RCH training to all of the NGO providers. This year's work plan calls for all of the SIAS NGO traveling physicians and institutional facilitators to be trained in IMCI, but the budget only provides for 33 of them. Only one (out of 4-6) community facilitator per NGO is scheduled to receive training (again, only 33 were budgeted). Only 10 vigilantes (out of 40-60) will be trained (in 33 NGOs). More people will receive training in FP, but no training is scheduled for other RH services.

Thus, there is an opportunity for the NGO Networks project to supplement RHC training for those SIAS NGOs that will not receive technical training through *Calidad en Salud*. Similar opportunities exist for coordination and collaboration in supervision, monitoring and other support services.

Obviously, it will be important for the NGO Networks CA and key NGO members to coordinate their training and technical assistance efforts with *Calidad en Salud* as well as with local MOH health staff.

. Annex F: Performance Monitoring Plan

Strategic Objective 3 and Related Intermediate Results

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
Strategic Objective 3: Better Health for Women and Children							
1. Total Fertility Rate **R4 Reported (text)**	Definition: Average number of children that would be born to a woman during her lifetime if she were to pass through all her childbearing years conforming to a current schedule of age-specific fertility rates. Unit: Avg. number of births/woman/lifetime	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3
2. Infant Mortality Rate **R4 Reported (text)**	Definition: Number of deaths to infants under 1 year of age per 1,000 live births (direct estimate). Unit: Infant deaths per 1,000 live births	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
Intermediate Result 1: More Rural Families Use Quality Maternal-Child Health Services and Better Household Practices							
3. National Contraceptive Prevalence Rate	Definition: Percentage of women aged 15-49 who are using (or whose partner is using) a contraceptive method at a particular point in time, reported for women who are either married on in sexual union. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	Performance Monitoring Review	INE, Macro, CDC & SO3
4. Couple Years of Protection **R4 Reported (table)**	Definition: This indicator measures the estimated protection (in terms of the number of couples protected for one year) from pregnancy provided by family planning methods based upon the volume of contraceptives sold or distributed. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor. Unit: CYP per year	Ministry of Health (MOH), Social Security Institute (IGSS), APROFAM, IPROFASA and other USAID-supported NGOs	Logistics information systems of partners	Annual	SO3	R4 and Performance Monitoring Review	SO3 and partner agencies

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
5. Unmet Need for Family Planning	Definition: Percentage of women in union who are fecund and who desire to either terminate or postpone childbearing, but who are not currently using a contraceptive method (includes currently pregnant women whose pregnancy was unwanted or mistimed and who were not using a contraceptive method at the time of conception). Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	Performance Monitoring Review	INE, Macro, CDC & SO3
6. Reduction in the Gap in Contraceptive Prevalence Rates Between the Mayan and Ladino Populations **R4 Reported (text)**	Definition: Contraceptive prevalence rate as described in indicator #3. Reduction in the gap will be a measurement of the percentage difference between the two population subgroups. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
7. Reduction in the Gap in Contraceptive Prevalence Rates Between the Urban and Rural Populations	Definition: Contraceptive prevalence rate as described in indicator #3. Reduction in the gap will be a measurement of the percentage difference between the two population subgroups. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	Performance Monitoring Review	INE, Macro, CDC & SO3
8. New Family Planning Users	Definition: Number of persons who accept a contraceptive method from a particular USAID-supported institution for the first time. Unit: Number of persons per year	MOH, IGSS, APROFAM and other USAID-supported NGOs	Service statistics of partners	Annual	SO3	Performance Monitoring Review	SO3 and partner agencies
9. Complete Vaccination Coverage of Children Aged 12-23 Months **R4 Reported (text)**	Definition: Percentage of children aged 12-23 months who have received all of the following vaccinations: DPT3, Polio3, BCG and measles. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
10. ORT or Increased Liquid Intake During Diarrheal Episodes **R4 Reported (text)**	Definition: For children under 5 years, the percentage of diarrheal episodes occuring in the 2 week period preceding the survey that are treated with oral rehydration therapy or increased fluids. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3
11. Pneumonia Cases Treated by a Health Provider **R4 Reported (text)**	Definition: For children under 5 years of age, the percentage of cases of cough and rapid breathing in the 2 week period prior to the survey that are treated by a health provider. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3
12. Percentage of Birth Intervals of at Least Two Years	Definition: Percentage of births showing a birth interval of at least two years. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	Performance Monitoring Review	INE, Macro, CDC & SO3

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
13. Percentage of births attended by a physician or nurse **R4 Reported (text)**	Definition: Percentage of births occurring in the five years prior to the survey, that were attended by a physician or nurse. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3
14. Met Need for Essential Obstetric Care **R4 Reported (table)**	Definition: The numerator includes the number of women with obstetric complications (excluding post-abortion complications) who are treated at project hospitals. The denominator includes the expected number of women giving birth (based on the crude birth rate) from the catchment area who have complications (or 15% of women with live births). Unit: Percentage	MOH hospitals	Maternal Neonatal Health Project information system	Annual	SO3	Performance Monitoring Review	SO3, MOH and Mother Care

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
15. Infants Under 6 Months Exclusively Breastfed **R4 Reported (text)**	Definition: Percentage of infants 0-5 months who are exclusively breastfed. Unit: Percentage	DHS	Population-based survey	1995, 1998-99, 2001-02	SO3	R4 and Performance Monitoring Review	INE, Macro, CDC & SO3
Intermediate Result 2: Public Health Programs are Well Managed							
16. Absence of Contraceptive Stockouts **4R Reported (table)**	Definition: The percentage of family planning service delivery points (clinics only) that reported no stockouts of contraceptive methods during the 6 month period prior to the interview. Unit: Percentage of clinics	MOH, IGSS and APROFAM (APROFAM to be measured through 2000 only)	Sample survey performed by JSI	1999 and yearly thereafter	SO3	R4 and Performance Monitoring Review	JSI, SO3 and partners
17. Local Maternity Centers Established by Community Members **R4 Reported through 1999**	Definition: The cumulative number of local maternity centers established with support by the Mother Care Project. Unit: Cumulative number of maternity centers	Mother Care/Maternal Neonatal Health Project	Project information system	Annual	SO3	Performance Monitoring Review	SO3 and Mother Care

(table)							

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
18. National HIV/ AIDS surveillance system provides annual sero-prevalence data **R4 Reported (text)**	Definition: This indicator is a yes/no annual indicator. It will measure whether or not annual seroprevalence data for 15-24 year olds is collected and used by policymakers in decision-making.	Universidad del Valle (UVG) with CDC	Sentinel surveillance of 15-24 year old post-partum women and commercial sex workers	Baseline in 2002 and annual thereafter	SO3	R4 and Performance Monitoring Review	SO3, UVG and CDC
19. Removal of Medical/ Institutional Barriers to Family Planning Services	Definition: This indicator will measure the net change in medical/institutional barriers to family planning services among USAID partners that provide family planning services. Unit: Net number of barriers removed.	Policy Project	Sample surveys of MOH, IGSS, APROFAM providers and review of institutional norms and government laws and regulations	1999, 2001 and 2003	SO3	Performance Monitoring Review	SO3, Policy Project and partners

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
Intermediate Result 3: Stronger Guatemalan Commitment to Integrated Women's Health							
20. Cumulative Number of Campaigns Advocating Women's Participation	Definition: This indicator measures the number of campaigns carried out by local organizations (with assistance from the Policy Project) advocating for women's participation in activities/decisions that affect their lives, including health. Unit: Number of organized campaigns	Policy Project	Policy Project information system	1999, 2001 and 2003	SO3	Performance Monitoring Review	SO3 and Policy Project
21. Number of GOG Plans that Use Information Provided by Policy Project **R4 Reported (table)**	Definition: Number of GOG plans (at any level) that indicate, in their development or final product, use of information provided or facilitated by the Policy Project or its partners Unit: Number of plans	Policy Project	Policy Project information system	Annual	SO3	Performance Monitoring Review	SO3 and Policy Project

PERFORMANCE INDICATOR	INDICATOR DEFINITION AND UNIT OF MEASURE	DATA SOURCE	METHOD/ APPROACH OF DATA COLLECTION OR CALCULATION	DATA ACQUISITION BY MISSION		ANALYSIS, USE & REPORTING	
				SCHEDULE/ FREQUENCY (all years refer to calendar years)	RESPONSIBLE PERSON(S) AND TEAM	SCHEDULE BY MANAGEMENT EVENT	RESPONSIBLE PERSON(S) AND TEAM
22. Policy Environment Score (PES)	Definition: The PES measures the extent to which the policy environment in a particular country contributes to improving reproductive health indicators. The questionnaire utilized includes family planning information and services, maternal health policy development, organizational structure, program resources, legal and regulatory environment and presence of program evaluation and research components. Unit: Score of 0 to 100 (number)	Policy Project	Survey conducted by Policy Project	2000 and 2003	SO3	Performance Monitoring Review	SO3 and Policy Project